

Summary Report

2017 Community Health Needs Assessment Report

Ephraim McDowell Fort Logan Hospital Service Area

Prepared for:
Ephraim McDowell Health

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Introduction



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About This Assessment

This Community Health Needs Assessment, a follow-up to similar studies conducted in 2011 and 2014, is a systematic, data-driven approach to determining the health status, behaviors and needs of residents in the service area of Ephraim McDowell Fort Logan Hospital. Subsequently, this information may be used to inform decisions and guide efforts to improve community health and wellness.

A Community Health Needs Assessment provides information so that communities may identify issues of greatest concern and decide to commit resources to those areas, thereby making the greatest possible impact on community health status.

This assessment was conducted on behalf of Ephraim McDowell Health by Professional Research Consultants, Inc. (PRC). PRC is a nationally-recognized healthcare consulting firm with extensive experience conducting Community Health Needs Assessments such as this in hundreds of communities across the United States since 1994.

Methodology

This assessment incorporates data from both quantitative and qualitative sources. Quantitative data input includes primary research (the PRC Community Health Survey) and secondary research (vital statistics and other existing health-related data); these quantitative components allow for comparison to benchmark data at the state and national levels. Qualitative data input includes primary research gathered through an Online Key Informant Survey of various community stakeholders.

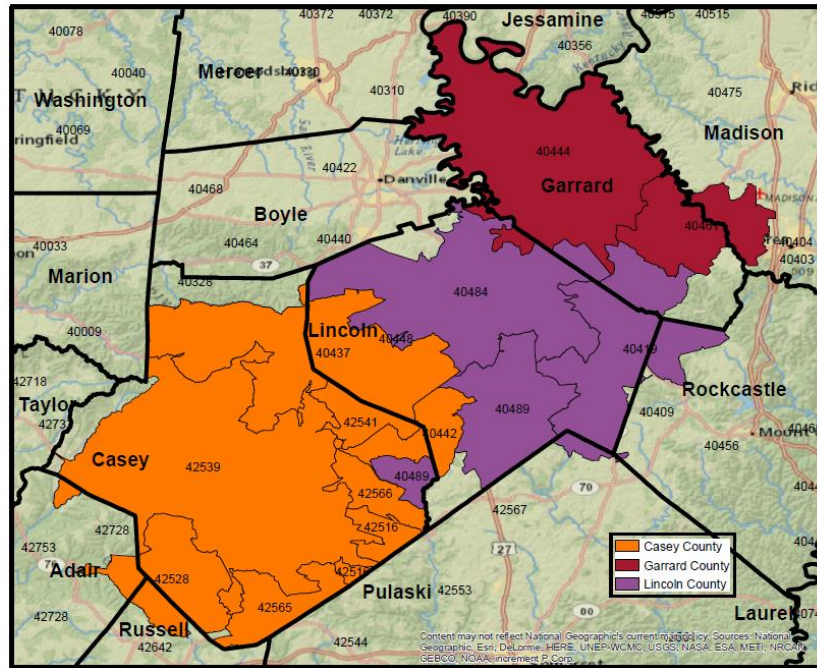
PRC Community Health Survey

Survey Instrument

The survey instrument used for this study is based largely on the Centers for Disease Control and Prevention (CDC) Behavioral Risk Factor Surveillance System (BRFSS), as well as various other public health surveys and customized questions addressing gaps in indicator data relative to health promotion and disease prevention objectives and other recognized health issues. The final survey instrument was developed by Ephraim McDowell Health and PRC.

Community Defined for This Assessment

The study area for the survey effort (referred to as the “EMFLH Service Area” in this report) includes the principal residential ZIP Codes in Casey, Garrard, and Lincoln counties in Kentucky, comprising the service area of Ephraim McDowell Fort Logan Hospital. This community definition is illustrated in the following map.



Sample Approach & Design

A precise and carefully executed methodology is critical in asserting the validity of the results gathered in the *PRC Community Health Survey*. Thus, to ensure the best representation of the population surveyed, a telephone interview methodology — one that incorporates both landline and cell phone interviews — was employed. The primary advantages of telephone interviewing are timeliness, efficiency, and random-selection capabilities.

The sample design used for this effort consisted of a random sample of 302 individuals age 18 and older in EMFLH Service Area. Because this study is part of a larger effort involving multiple regions and hospital service areas, the surveys were distributed among various strata. Once the interviews were completed, these were weighted in proportion to the actual population distribution so as to appropriately represent the EMFLH Service Area as a whole. All administration of the surveys, data collection and data analysis was conducted by Professional Research Consultants, Inc. (PRC).

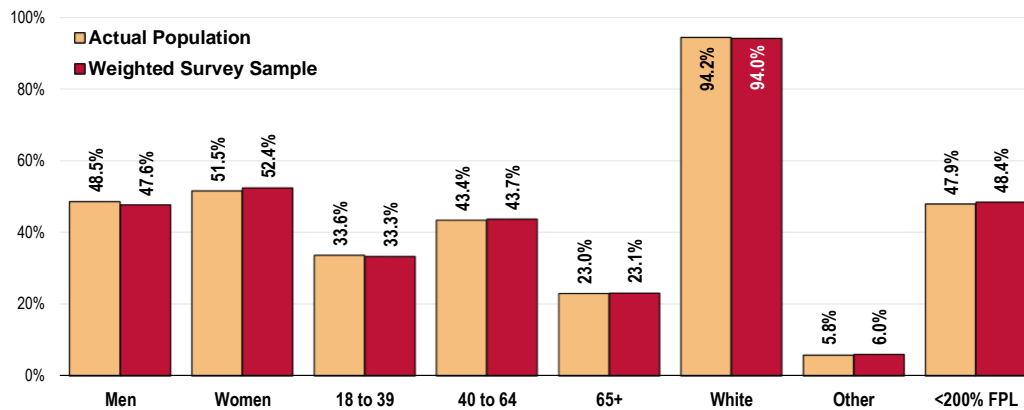
For statistical purposes, the maximum rate of error associated with a sample size of 302 respondents is $\pm 5.7\%$ at the 95 percent level of confidence.

Sample Characteristics

To accurately represent the population studied, PRC strives to minimize bias through application of a proven telephone methodology and random-selection techniques. And, while this random sampling of the population produces a highly representative sample, it is a common and preferred practice to “weight” the raw data to improve this representativeness even further. This is accomplished by adjusting the results of a random sample to match the geographic distribution and demographic characteristics of the population surveyed (poststratification), so as to eliminate any naturally occurring bias.

The following chart outlines the characteristics of the EMFLH Service Area sample for key demographic variables, compared to actual population characteristics revealed in census data. [Note that the sample consisted solely of area residents age 18 and older; data on children were given by proxy by the person most responsible for that child’s healthcare needs, and these children are not represented demographically in this chart.]

Population & Survey Sample Characteristics (EMFLH Service Area, 2017)



Sources: • Census 2010, Summary File 3 (SF 3). US Census Bureau.
• 2017 PRC Community Health Survey, Professional Research Consultants, Inc.

Further note that the poverty descriptions and segmentation used in this report are based on administrative poverty thresholds determined by the US Department of Health & Human Services. These guidelines define poverty status by household income level and number of persons in the household (e.g., the 2016 guidelines place the poverty threshold for a family of four at \$24,300 annual household income or lower). In sample segmentation: “**low income**” refers to community members living in a household with defined poverty status or living just above the poverty level, earning up to twice (<200% of) the poverty threshold; “**mid/high income**” refers to those households living on incomes which are twice or more (≥200% of) the federal poverty level.

The sample design and the quality control procedures used in the data collection ensure that the sample is representative. Thus, the findings may be generalized to the total population of community members in the defined area with a high degree of confidence.

Online Key Informant Survey

To solicit input from key informants, those individuals who have a broad interest in the health of the community, an Online Key Informant Survey was also implemented as part of this process. A list of recommended participants was provided by Ephraim McDowell Health; this list included names and contact information for physicians, public health representatives, social service providers, and a variety of other community leaders. Potential participants were chosen because of their ability to identify primary concerns of the populations with whom they work, as well as of the community overall.

Key informants were contacted by email, introducing the purpose of the survey and providing a link to take the survey online; reminder emails were sent as needed to increase participation. Note that stakeholder input was drawn from a more regional administration that also included Boyle, Washington, and Mercer counties. In all, 45 community stakeholders took part in the Online Key Informant Survey, as outlined below:

Online Key Informant Survey Participation		
Key Informant Type	Number Invited	Number Participating
Physician	29	6
Public Health Expert	6	4
Social Services Representative	2	2
Community/Business Leader	120	33

Final participation included representatives of the organizations outlined below.

- Boyle County Fiscal Court
- Boyle County Health Department
- Boyle County Property Valuation
- City Commissioner
- City of Crab Orchard
- City of Lancaster
- Danville City Commission
- Ephraim McDowell Health
- Ephraim McDowell Regional Medical Center
- Casey County Property Value Administrator's Office
- Funeral Home
- Heart of Kentucky United Way
- Lake Cumberland District Health Department
- Lancaster City Council
- Lincoln County Fiscal Court
- Lincoln County Schools
- Mercer County Health Department
- Mercer County Schools
- Presbyterian Church of Danville
- The Salvation Army
- Washington County Property Value Administrator's Office

Through this process, input was gathered from several individuals whose organizations work with low-income, minority populations, or other medically underserved populations.

Minority/medically underserved populations represented:

African-Americans, children raised by others (not parents), deaf, disabled, elderly, free- and reduced-lunch population, Hispanics, immigrants, low income, Medicare/Medicaid recipients, rural, undocumented, unemployed, uninsured/underinsured

In the online survey, key informants were asked to rate the degree to which various health issues are a problem in their own community. Follow-up questions asked them to describe why they identify problem areas as such, and how these might be better addressed. Results of their ratings, as well as their verbatim comments, are included throughout this report as they relate to the various other data presented.

NOTE: These findings represent qualitative rather than quantitative data. The Online Key Informant Survey was designed to gather input from participants regarding their opinions and perceptions of the health of the residents in the area. Thus, these findings are not necessarily based on fact.

Public Health, Vital Statistics & Other Data

A variety of existing (secondary) data sources was consulted to complement the research quality of this Community Health Needs Assessment. Data for the EMFLH Service Area were obtained from the following sources (specific citations are included with the graphs throughout this report):

- Center for Applied Research and Environmental Systems (CARES)
- Centers for Disease Control & Prevention, Office of Infectious Disease, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
- Centers for Disease Control & Prevention, Office of Public Health Science Services, Center for Surveillance, Epidemiology and Laboratory Services, Division of Health Informatics and Surveillance (DHIS)
- Centers for Disease Control & Prevention, Office of Public Health Science Services, National Center for Health Statistics
- Community Commons
- National Cancer Institute, State Cancer Profiles
- US Census Bureau, American Community Survey
- US Census Bureau, County Business Patterns
- US Census Bureau, Decennial Census
- US Department of Agriculture, Economic Research Service
- US Department of Health & Human Services
- US Department of Health & Human Services, Health Resources and Services Administration (HRSA)
- US Department of Justice, Federal Bureau of Investigation
- US Department of Labor, Bureau of Labor Statistics

Benchmark Data

Trending

Similar surveys were administered in EMFLH Service Area in 2011 and 2014 by PRC on behalf of Ephraim McDowell Health. Trending data, as revealed by comparison to prior survey results, are provided throughout this report whenever available. Historical data for secondary data indicators are also included for the purposes of trending.

State Risk Factor Data

Statewide risk factor data are provided where available as an additional benchmark against which to compare local survey findings; these data are reported in the most recent *BRFSS (Behavioral Risk Factor Surveillance System) Prevalence and Trend Data* published by the Centers for Disease Control and Prevention and the US Department of Health & Human Services. State-level vital statistics are also provided for comparison of secondary data indicators.

Nationwide Risk Factor Data

Nationwide risk factor data, which are also provided in comparison charts, are taken from the *2015 PRC National Health Survey*; the methodological approach for the national study is identical to that employed in this assessment, and these data may be generalized to the US population with a high degree of confidence.

National-level vital statistics are also provided for comparison of secondary data indicators.

Healthy People 2020

Healthy People provides science-based, 10-year national objectives for improving the health of all Americans. The Healthy People initiative is grounded in the principle that setting national objectives and monitoring progress can motivate action. For three decades, Healthy People has established benchmarks and monitored progress over time in order to:

- Encourage collaborations across sectors.
- Guide individuals toward making informed health decisions.
- Measure the impact of prevention activities.



Healthy People 2020 is the product of an extensive stakeholder feedback process that is unparalleled in government and health. It integrates input from public health and prevention experts, a wide range of federal, state and local government officials, a consortium of more than 2,000 organizations, and perhaps most importantly, the public. More than 8,000 comments were considered in drafting a comprehensive set of Healthy People 2020 objectives.

Determining Significance

Differences noted in this report represent those determined to be significant. For survey-derived indicators (which are subject to sampling error), statistical significance is determined based on confidence intervals (at the 95 percent confidence level) using question-specific samples and response rates. For secondary data indicators (which do not carry sampling error, but might be subject to reporting error), "significance," for the purpose of this report, is determined by a 5% variation from the comparative measure.

Information Gaps

While this assessment is quite comprehensive, it cannot measure all possible aspects of health in the community, nor can it adequately represent all possible populations of interest. It must be recognized that these information gaps might in some ways limit the ability to assess all of the community's health needs.

For example, certain population groups — such as the homeless, institutionalized persons, or those who only speak a language other than English or Spanish — are not represented in the survey data. Other population groups — for example, pregnant women, lesbian/gay/bisexual/transgender residents, undocumented residents, and members of certain racial/ethnic or immigrant groups — might not be identifiable or might not be represented in numbers sufficient for independent analyses.

In terms of content, this assessment was designed to provide a comprehensive and broad picture of the health of the overall community. However, there are certainly medical conditions that are not specifically addressed.

IRS Form 990, Schedule H Compliance

For non-profit hospitals, a Community Health Needs Assessment (CHNA) also serves to satisfy certain requirements of tax reporting, pursuant to provisions of the Patient Protection & Affordable Care Act of 2010. To understand which elements of this report relate to those requested as part of hospitals' reporting on IRS Form 990 Schedule H, the following table cross-references related sections.

IRS Form 990, Schedule H (2016)	See Report Page
Part V Section B Line 3a <i>A definition of the community served by the hospital facility</i>	5
Part V Section B Line 3b <i>Demographics of the community</i>	33
Part V Section B Line 3c <i>Existing health care facilities and resources within the community that are available to respond to the health needs of the community</i>	138
Part V Section B Line 3d <i>How data was obtained</i>	5
Part V Section B Line 3e <i>The significant health needs of the community</i>	13
Part V Section B Line 3f <i>Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups</i>	Addressed Throughout
Part V Section B Line 3g <i>The process for identifying and prioritizing community health needs and services to meet the community health needs</i>	16
Part V Section B Line 3h <i>The process for consulting with persons representing the community's interests</i>	7
Part V Section B Line 3i <i>The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)</i>	142

Summary of Findings



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Significant Health Needs of the Community

The following “areas of opportunity” represent the significant health needs of the community, based on the information gathered through this Community Health Needs Assessment and the guidelines set forth in Healthy People 2020. From these data, opportunities for health improvement exist in the area with regard to the following health issues (see also the summary tables presented in the following section).

The Areas of Opportunity were determined after consideration of various criteria, including: standing in comparison with benchmark data (particularly national data); identified trends; the preponderance of significant findings within topic areas; the magnitude of the issue in terms of the number of persons affected; and the potential health impact of a given issue. These also take into account those issues of greatest concern to the community stakeholders (key informants) giving input to this process.

Areas of Opportunity Identified Through This Assessment	
Access to Healthcare Services	<ul style="list-style-type: none"> • Lack of Health Insurance • Barriers to Access <ul style="list-style-type: none"> ◦ Cost of Prescriptions • Skipping/Stretching Prescriptions • Primary Care Physician Ratio • Ratings of Local Healthcare
Cancer	<ul style="list-style-type: none"> • Cancer is a leading cause of death. • Cancer Deaths <ul style="list-style-type: none"> ◦ Including Lung Cancer, Female Breast Cancer, Colorectal Cancer Deaths • Cancer Incidence <ul style="list-style-type: none"> ◦ Including Lung and Colorectal Cancer Incidence • Cervical Cancer Screening • Cancer ranked as a top concern in the Online Key Informant Survey.
Dementia, Including Alzheimer's Disease	<ul style="list-style-type: none"> • Alzheimer's Disease Deaths
Diabetes	<ul style="list-style-type: none"> • Diabetes Deaths • Diabetes ranked as a top concern in the Online Key Informant Survey.
Heart Disease & Stroke	<ul style="list-style-type: none"> • Cardiovascular disease is a leading cause of death. • Heart Disease Deaths • Stroke Prevalence • High Blood Pressure Prevalence • Overall Cardiovascular Risk
Infant Health & Family Planning	<ul style="list-style-type: none"> • Low-Weight Births • Infant Mortality • Teen Births
Injury & Violence	<ul style="list-style-type: none"> • Unintentional Injury Deaths <ul style="list-style-type: none"> ◦ Including Motor Vehicle Crash Deaths • Falls (Age 45+) • Firearm-Related Deaths • Firearm Prevalence <ul style="list-style-type: none"> ◦ Including in Homes With Children • Firearm Storage/Safety

—continued on the next page—

Areas of Opportunity (continued)	
Kidney Disease	<ul style="list-style-type: none"> • Kidney Disease Deaths
Mental Health	<ul style="list-style-type: none"> • Diagnosed Depression • Symptoms of Chronic Depression • [Diagnosed Depression] Seeking Professional Help • Stress • Suicide Deaths
Nutrition, Physical Activity & Weight	<ul style="list-style-type: none"> • Fruit/Vegetable Consumption • Difficulty Accessing Fresh Produce • Medical Advice on Weight • Child Overweight & Obesity (Age 5-17) • Meeting Physical Activity Guidelines • Nutrition, Physical Activity & Weight ranked as a top concern in the Online Key Informant Survey.
Oral Health	<ul style="list-style-type: none"> • Dental Insurance Coverage • Regular Dental Care
Potentially Disabling Conditions	<ul style="list-style-type: none"> • Activity Limitations • Arthritis Prevalence (Age 50+) • Sciatica/Back Pain Prevalence • Blindness/Vision Trouble • Deafness/Hearing Trouble • Caregiving
Respiratory Diseases	<ul style="list-style-type: none"> • Chronic Lower Respiratory Disease (CLRD) Deaths • Chronic Obstructive Pulmonary Disease (COPD) Prevalence • Pneumonia/Influenza Deaths • Flu Vaccination (Age 65+ and High-Risk 18-64)
Sexually Transmitted Diseases	<ul style="list-style-type: none"> • Condom Use
Substance Abuse	<ul style="list-style-type: none"> • Cirrhosis/Liver Disease Deaths • Excessive Drinking • Drinking and Driving • Drug-Induced Deaths • Substance Abuse ranked as a top concern in the Online Key Informant Survey.
Tobacco Use	<ul style="list-style-type: none"> • Cigarette Smoking Prevalence • Environmental Tobacco Smoke Exposure at Home <ul style="list-style-type: none"> ◦ Including Among Households With Children • Cigar Smoking Prevalence • Smokeless Tobacco Prevalence • Tobacco Use ranked as a top concern in the Online Key Informant Survey.

Community Feedback on Prioritization of Health Needs

Prioritization included input from community stakeholders. On June 6, 2017 approximately 10 community and business leaders, social service providers, as well as internal stakeholders of the hospital gathered to evaluate, discuss and prioritize health issues for the hospital's community, based on findings of the 2017 PRC Community Health Needs Assessment (CHNA).

A list of recommended participants for the group was provided by the sponsors. Potential participants were chosen because of their ability to identify primary concerns of the populations with whom they work, as well as of the community overall. Participants included a representative of public health, as well as several individuals who work with low-income, minority or other medically underserved populations, and those who work with persons with chronic disease conditions.

The meeting with a presentation of key findings from the CHNA, highlighting the significant health issues identified from the research (see Areas of Opportunity above).

Following the data review, a group dialogue occurred, allowing participants to advocate for any of the health issues discussed. Finally, participants were provided an overview of the prioritization exercise that followed.

In order to assign priority to the identified health needs (i.e., Areas of Opportunity), the participants were asked to evaluate each health issue along two criteria:

- **Scope & Severity** — The first rating was to gauge the magnitude of the problem in consideration of the following:
 - How many people are affected?
 - How does the local community data compare to state or national levels, or Healthy People 2020 targets?
 - To what degree does each health issue lead to death or disability, impair quality of life, or impact other health issues?

- **Ability to Impact** — A second rating was designed to measure the perceived likelihood of the hospital having a positive impact on each health issue, given available resources, competencies, spheres of influence, etc.

Another group discussion occurred, and the facilitator ranked the priorities based on feedback from each participant at the table. This process yielded the following prioritized list of community health needs:

1. **Diabetes**
2. **Access to Healthcare Services**
3. **Cancer-Early Detection & Prevention**
4. **Cardiovascular Disease & Related Risk Factors**
5. **Nutrition, Physical Activity & Weight**
6. **Injury & Violence**

7. **Substance Abuse**
8. **Dementia, Including Alzheimer's Disease**
9. **Mental Health**
10. **Sexually Transmitted Diseases & HIV/AIDS**
11. **Oral Health**
12. **Infant Health & Family Planning**
13. **Respiratory Diseases**
14. **Tobacco Use**
15. **Chronic Kidney Disease**

Hospital Implementation Strategy

The top priority areas, numbers 1-5 above, and plans to address these, will be integrated into the Implementation Strategy. The rationale for selecting these areas is an understanding that impacting these would also impact many other areas of need identified in the assessment, numbers 6-15 above. These areas also represent a continuation of existing work and allow the hospital to build on past successes.

Summary Data

Comparisons With Benchmark Data

The following tables provide an overview of indicators in the EMFLH Service Area. These data are grouped to correspond with the Focus Areas presented in Healthy People 2020.

Reading the Data Summary Tables

■ In the following charts, EMFLH Service Area results are shown in the larger, blue column. For survey-derived indicators, this column represents the ZIP Code–defined hospital service area; for data from secondary sources, this column represents findings for the three-county area as a whole. *Tip: Indicator labels beginning with a “%” symbol are taken from the PRC Community Health Survey; the remaining indicators are taken from secondary data sources.*












■ The columns to the right of the EMFLH Service Area column provide trend comparisons (trending from the earliest data year available), as well as comparisons between local data and any available state and national findings, and Healthy People 2020 targets. Symbols indicate whether EMFLH Service Area compares favorably (☀️), unfavorably (🌧️), or comparably (☁️) to these external data.

Note that blank table cells signify that data are not available or are not reliable for that area and/or for that indicator.

Social Determinants	EMFLH Service Area vs. Benchmarks				
	EMFLH Service Area	vs. KY	vs. US	vs. HP2020	TREND
Linguistically Isolated Population (Percent)	0.3	☀️ 1.2	☀️ 4.6		
Population in Poverty (Percent)	24.1	🌧️ 18.9	🌧️ 15.5		
Population Below 200% FPL (Percent)	48.1	🌧️ 39.4	🌧️ 34.3		
Children Below 200% FPL (Percent)	58.9	🌧️ 48.4	🌧️ 44.0		
No High School Diploma (Age 25+, Percent)	23.0	🌧️ 15.8	🌧️ 13.4		
Unemployment Rate (Age 16+, Percent)	6.5	🌧️ 5.4	🌧️ 5.3	☁️ 6.6	
		☀️ better	☁️ similar	🌧️ worse	











Overall Health

% "Fair/Poor" Physical Health
% Activity Limitations
% Caregiver to a Friend/Family Member

EMFLH Service Area	EMFLH Service Area vs. Benchmarks			TREND
	vs. KY	vs. US	vs. HP2020	
29.4	 22.2	 18.3		 31.8
28.6	 26.5	 20.0		 28.8
34.1		 20.9		 32.5
 better  similar  worse				



























Access to Health Services

% [Age 18-64] Lack Health Insurance
% [Private/Medicaid <65] Have Coverage Through Kynect/ACA
% Difficulty Accessing Healthcare in Past Year (Composite)
% Inconvenient Hrs Prevented Dr Visit in Past Year
% Cost Prevented Getting Prescription in Past Year
% Cost Prevented Physician Visit in Past Year
% Difficulty Getting Appointment in Past Year
% Difficulty Finding Physician in Past Year
% Transportation Hindered Dr Visit in Past Year

EMFLH Service Area	EMFLH Service Area vs. Benchmarks			TREND
	vs. KY	vs. US	vs. HP2020	
17.5	 8.1	 10.1	 0.0	 24.8
17.3		 14.9		
40.6		 35.0		 51.2
16.9		 14.4		 17.0
15.4		 9.5		 29.0
13.9	 12.3	 11.5		 23.3
17.2		 15.4		 18.2
8.4		 8.7		 13.2
8.0		 5.0		 12.4











Access to Health Services (continued)

% Skipped Prescription Doses to Save Costs
% Difficulty Getting Child's Healthcare in Past Year
% Low Health Literacy
Primary Care Doctors per 100,000
% [Age 18+] Have a Specific Source of Ongoing Care
% [Age 18-64] Have a Specific Source of Ongoing Care
% [Age 65+] Have a Specific Source of Ongoing Care
% Have Had Routine Checkup in Past Year
% Child Has Had Checkup in Past Year
% Two or More ER Visits in Past Year
% Rate Local Healthcare "Fair/Poor"

EMFLH Service Area	EMFLH Service Area vs. Benchmarks			TREND
	vs. KY	vs. US	vs. HP2020	
17.8		 10.2	 32.8	
1.6		 3.9	 1.0	
24.7		 23.3		
28.0	 74.0	 87.8	 36.8	
82.2		 74.0	 95.0	
80.9		 73.1	 89.4	
86.3		 76.8	 100.0	
71.1	 75.2	 70.5	 64.3	
88.9		 89.3	 88.5	
12.0		 8.5	 10.8	
21.4		 14.2	 19.9	
<div style="display: flex; justify-content: space-around; align-items: center;"> <div style="text-align: center;"> better</div> <div style="text-align: center;"> similar</div> <div style="text-align: center;"> worse</div> </div>				

























Arthritis, Osteoporosis & Chronic Back Conditions

% [50+] Arthritis/Rheumatism
% [50+] Osteoporosis
% Sciatica/Chronic Back Pain

EMFLH Service Area	EMFLH Service Area vs. Benchmarks			TREND
	vs. KY	vs. US	vs. HP2020	
45.4		 32.0		 55.2
12.9		 8.7	 5.3	 17.4
37.4		 19.4		 28.0
 better  similar  worse				

























Cancer

Cancer (Age-Adjusted Death Rate)
Lung Cancer (Age-Adjusted Death Rate)
Female Breast Cancer (Age-Adjusted Death Rate)
Colorectal Cancer (Age-Adjusted Death Rate)
Prostate Cancer Incidence per 100,000
Female Breast Cancer Incidence per 100,000
Lung Cancer Incidence per 100,000
Colorectal Cancer Incidence per 100,000
% Skin Cancer

EMFLH Service Area	EMFLH Service Area vs. Benchmarks			TREND
	vs. KY	vs. US	vs. HP2020	
214.2	 198.0	 161.0	 161.4	 226.7
86.8	 66.9	 42.0	 45.5	
25.0	 21.0	 20.6	 20.7	
19.5	 17.1	 14.4	 14.5	
110.3	 118.1	 123.4		
117.9	 122.0	 123.4		
101.2	 96.4	 62.6		
59.3	 50.8	 40.6		
7.9	 7.6	 7.7		 6.2










Cancer (continued)

% Cancer (Other Than Skin)
% [Women 50-74] Mammogram in Past 2 Years
% [Women 21-65] Pap Smear in Past 3 Years
% [Age 50+] Sigmoid/Colonoscopy Ever
% [Age 50+] Blood Stool Test in Past 2 Years
% [Age 50-75] Colorectal Cancer Screening

EMFLH Service Area	EMFLH Service Area vs. Benchmarks			TREND
	vs. KY	vs. US	vs. HP2020	
7.6	 7.8	 7.7		 6.1
71.5	 79.6	 80.3	 81.1	 69.9
74.4	 81.3	 84.8	 93.0	 87.1
73.8	 69.6	 75.6		 66.9
28.6	 14.6	 31.8		 34.5
70.4	 67.2	 74.5	 70.5	 67.9
 better  similar  worse				








Chronic Kidney Disease

Kidney Disease (Age-Adjusted Death Rate)
% Kidney Disease

EMFLH Service Area	EMFLH Service Area vs. Benchmarks			TREND
	vs. KY	vs. US	vs. HP2020	
20.1	 19.9	 13.3		 30.9
5.2	 3.0	 3.6		 3.5
 better  similar  worse				












Dementias, Including Alzheimer's Disease


Alzheimer's Disease (Age-Adjusted Death Rate)
% [Age 45+] Increasing Confusion/Memory Loss in Past Yr


EMFLH Service Area	EMFLH Service Area vs. Benchmarks			TREND
	vs. KY	vs. US	vs. HP2020	
46.7	 32.8	 26.1		 27.0
15.8		 12.8		
 better  similar  worse				


Diabetes

Diabetes Mellitus (Age-Adjusted Death Rate)
% Diabetes/High Blood Sugar
% Borderline/Pre-Diabetes
% [Non-Diabetes] Blood Sugar Tested in Past 3 Years

EMFLH Service Area	EMFLH Service Area vs. Benchmarks			TREND
	vs. KY	vs. US	vs. HP2020	
19.7	 25.2	 21.1	 20.5	 15.0
17.4	 13.4	 14.5		 16.1
8.6		 5.7		 6.5
49.9		 55.1		 55.2





better



similar



worse


Family Planning

Teen Births per 1,000 (Age 15-19)

EMFLH Service Area	EMFLH Service Area vs. Benchmarks			TREND
	vs. KY	vs. US	vs. HP2020	
56.9	 48.4	 36.6		 60.1




better



similar



worse


Hearing & Other Sensory or Communication Disorders

% Deafness/Trouble Hearing

EMFLH Service Area	EMFLH Service Area vs. Benchmarks			TREND
	vs. KY	vs. US	vs. HP2020	
13.6		 8.6		 16.4






































better


similar


worse








Heart Disease & Stroke

Diseases of the Heart (Age-Adjusted Death Rate)
Stroke (Age-Adjusted Death Rate)
% Heart Disease (Heart Attack, Angina, Coronary Disease)
% Stroke
% Blood Pressure Checked in Past 2 Years
% Told Have High Blood Pressure (Ever)
% [HBP] Taking Action to Control High Blood Pressure
% Cholesterol Checked in Past 5 Years
% Told Have High Cholesterol (Ever)
% [HBC] Taking Action to Control High Blood Cholesterol
% 1+ Cardiovascular Risk Factor

EMFLH Service Area	EMFLH Service Area vs. Benchmarks			TREND
	vs. KY	vs. US	vs. HP2020	
182.0	 200.6	 168.4	 156.9	 213.7
35.8	 41.4	 36.8	 34.8	 51.9
10.2		 6.9		 13.7
5.5	 4.3	 2.6		 4.9
93.6		 93.6	 92.6	 95.8
48.4	 39.0	 36.5	 26.9	 46.4
89.8		 92.5		 94.9
89.9	 76.5	 87.4	 82.1	 87.6
34.9		 33.5	 13.5	 39.9
88.8		 84.2		 90.4
92.6		 83.0		 88.8
 better  similar  worse				


















HIV

HIV Prevalence per 100,000
% [Age 18-44] HIV Test in the Past Year

EMFLH Service Area	EMFLH Service Area vs. Benchmarks			TREND
	vs. KY	vs. US	vs. HP2020	
45.8	 159.4	 353.2		
19.2		 21.3	 13.3	
	 better	 similar	 worse	
















Immunization & Infectious Diseases

% [Age 65+] Flu Vaccine in Past Year
% [High-Risk 18-64] Flu Vaccine in Past Year
% [Age 65+] Pneumonia Vaccine Ever
% [High-Risk 18-64] Pneumonia Vaccine Ever

EMFLH Service Area	EMFLH Service Area vs. Benchmarks			TREND
	vs. KY	vs. US	vs. HP2020	
51.0	 67.3	 58.9	 70.0	 69.3
30.1		 48.0	 70.0	 43.2
67.5	 74.1	 76.3	 90.0	 71.9
40.5		 38.7	 60.0	 33.6
	 better	 similar	 worse	















Injury & Violence Prevention


Unintentional Injury (Age-Adjusted Death Rate)
Motor Vehicle Crashes (Age-Adjusted Death Rate)
% "Always" Wear Seat Belt
Firearm-Related Deaths (Age-Adjusted Death Rate)


EMFLH Service Area	EMFLH Service Area vs. Benchmarks			TREND
	vs. KY	vs. US	vs. HP2020	
62.9	 60.0	 41.0	 36.4	 66.4
22.7	 15.7	 10.6	 12.4	 23.4
76.3	 85.0		 92.0	 75.7
14.0	 14.3	 10.6	 9.3	 11.8


Injury & Violence Prevention (continued)

% Firearm in Home
% [Homes With Children] Firearm in Home
% [Homes With Firearms] Weapon(s) Unlocked & Loaded
Violent Crime per 100,000
% Victim of Violent Crime in Past 5 Years
% Victim of Domestic Violence (Ever)
% [Age 45+] Fell in the Past Year
% [Age 45+] Injured from a Fall in the Past Year

EMFLH Service Area	EMFLH Service Area vs. Benchmarks			TREND
	vs. KY	vs. US	vs. HP2020	
71.4		 33.8	 65.0	
71.8		 31.0	 64.7	
39.0		 20.4	 22.3	
58.4	 237.0	 395.5		
2.6		 2.3	 3.8	
18.1		 15.1	 14.7	
36.9		 28.2		
13.9		 30.2		










better



similar



worse


Maternal, Infant & Child Health

Infant Death Rate
Low Birth Weight (<2,500 grams)

EMFLH Service Area	EMFLH Service Area vs. Benchmarks			TREND
	vs. KY	vs. US	vs. HP2020	
11.1	 6.8	 5.9	 6.0	 5.4
9.4	 9.1	 8.2	 7.8	 9.2




















better



similar



worse


Mental Health & Mental Disorders

% "Fair/Poor" Mental Health
% Diagnosed Depression
% Symptoms of Chronic Depression (2+ Years)
Suicide (Age-Adjusted Death Rate)
% Have Ever Sought Help for Mental Health
% [Those With Diagnosed Depression] Seeking Help
% Unable to Get Mental Health Svcs in Past Yr
% Typical Day Is "Extremely/Very" Stressful

EMFLH Service Area	EMFLH Service Area vs. Benchmarks			TREND
	vs. KY	vs. US	vs. HP2020	
17.1		 15.5	 20.6	
26.8	 18.8	 17.9	 27.5	
36.6		 29.9	 40.2	
18.3	 16.2	 13.0	 10.2	 12.4
24.5		 27.4	 26.6	
73.4		 91.7	 73.8	
4.8		 4.4		
16.6		 11.7	 11.9	









better


similar


worse






























Nutrition, Physical Activity & Weight


% Eat 5+ Servings of Fruit or Vegetables per Day
% "Very/Somewhat" Difficult to Buy Fresh Produce
Population With Low Food Access (Percent)
% Food Insecure


EMFLH Service Area	EMFLH Service Area vs. Benchmarks			TREND
	vs. KY	vs. US	vs. HP2020	
36.1		 27.4	 47.8	
34.6		 21.9	 28.3	
7.8	 18.0	 22.4		
21.7		 25.9		


Nutrition, Physical Activity & Weight (continued)

% Healthy Weight (BMI 18.5-24.9)
% Overweight (BMI 25+)
% Obese (BMI 30+)
% Medical Advice on Weight in Past Year
% [Overweights] Counseled About Weight in Past Year
% [Obese Adults] Counseled About Weight in Past Year
% Child [Age 5-17] Healthy Weight
% Children [Age 5-17] Overweight (85th Percentile)
% Children [Age 5-17] Obese (95th Percentile)
% No Leisure-Time Physical Activity
% Meeting Physical Activity Guidelines
% Child [Age 2-17] Physically Active 1+ Hours per Day

EMFLH Service Area	EMFLH Service Area vs. Benchmarks			TREND
	vs. KY	vs. US	vs. HP2020	
29.2	 30.9	 32.9	 33.9	 27.6
70.4	 67.2	 65.2		 71.3
38.8	 34.6	 33.4	 30.5	 34.1
21.3		 20.4		 29.6
26.7		 27.1		
37.8		 40.8		
38.7		 67.2		
50.6		 24.2		 40.0
30.1		 9.5	 14.5	 25.6
26.7	 28.2	 27.9	 32.6	 32.4
17.0	 18.0	 23.6	 20.1	
59.8		 47.9		











better



similar



worse


Oral Health

% [Age 18+] Dental Visit in Past Year
% Child [Age 2-17] Dental Visit in Past Year
% Have Dental Insurance

EMFLH Service Area	EMFLH Service Area vs. Benchmarks			TREND
	vs. KY	vs. US	vs. HP2020	
52.9	 61.0	 67.2	 49.0	 54.8
87.4		 90.7	 49.0	 71.1
55.7		 66.5		 47.5
















better



similar



worse


Respiratory Diseases

CLRD (Age-Adjusted Death Rate)
Pneumonia/Influenza (Age-Adjusted Death Rate)
% COPD (Lung Disease)
% [Adult] Currently Has Asthma
% [Child 0-17] Currently Has Asthma

EMFLH Service Area	EMFLH Service Area vs. Benchmarks			TREND
	vs. KY	vs. US	vs. HP2020	
76.9	 64.2	 41.4		 66.4
23.6	 19.7	 15.4		 31.5
19.1	 12.1	 9.5		 14.2
9.2	 11.9	 9.5		 8.2
10.4		 6.5		 10.5










better





similar


worse

Sexually Transmitted Diseases






















Gonorrhea Incidence per 100,000
Chlamydia Incidence per 100,000
% [Unmarried 18-64] 3+ Sexual Partners in Past Year
% [Unmarried 18-64] Using Condoms




EMFLH Service Area	EMFLH Service Area vs. Benchmarks			TREND
	vs. KY	vs. US	vs. HP2020	
36.6	 99.0	 110.7		
308.6	 400.4	 456.1		
14.5		 10.3		 13.1
26.2		 44.5		 27.1

 better
  similar
  worse

Substance Abuse






















Cirrhosis/Liver Disease (Age-Adjusted Death Rate)
% Current Drinker
% Excessive Drinker
% Drinking & Driving in Past Month
Drug-Induced Deaths (Age-Adjusted Death Rate)
% Illicit Drug Use in Past Month
% Ever Sought Help for Alcohol or Drug Problem


EMFLH Service Area	EMFLH Service Area vs. Benchmarks			TREND
	vs. KY	vs. US	vs. HP2020	
11.7	 11.6	 10.5	 8.2	 12.5
31.1	 40.8	 59.7		 25.0
16.9		 22.2	 25.4	 8.6
1.5		 4.1		 0.0
20.2	 27.2	 15.8	 11.3	 19.0
0.4		 3.0	 7.1	 3.3
2.4		 4.1		 2.9


 better
  similar
  worse


Tobacco Use

% Current Smoker
% Someone Smokes at Home
% [Nonsmokers] Someone Smokes in the Home
% [Household With Children] Someone Smokes in the Home
% [Smokers] Received Advice to Quit Smoking
% [Smokers] Have Quit Smoking 1+ Days in Past Year
% Smoke Cigars
% Use Smokeless Tobacco
% Currently Use Electronic Cigarettes

EMFLH Service Area	EMFLH Service Area vs. Benchmarks			TREND
	vs. KY	vs. US	vs. HP2020	
27.2	 26.0	 14.0	 12.0	 21.3
22.6		 10.2		 21.0
6.6		 3.9		
24.3		 10.2		
73.1		 76.0		 65.1
54.2		 43.7	 80.0	 61.1
8.9		 3.6	 0.2	 4.3
5.9	 7.3	 3.0	 0.3	 6.8
5.5		 3.8		







better



similar



worse


Vision

% Blindness/Trouble Seeing
% Eye Exam in Past 2 Years

EMFLH Service Area	EMFLH Service Area vs. Benchmarks			TREND
	vs. KY	vs. US	vs. HP2020	
13.7	 6.8	 7.3		 10.9
58.2		 59.3		 57.7


better

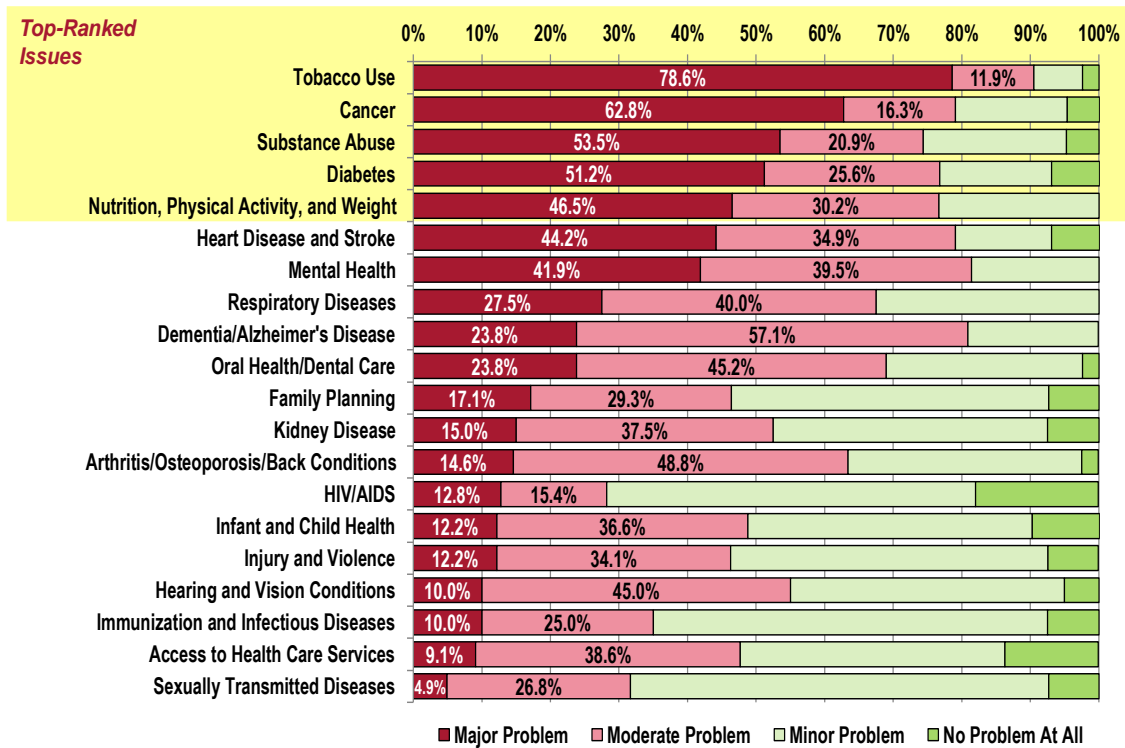

similar


worse

Summary of Key Informant Perceptions

In the Online Key Informant Survey, community stakeholders were asked to rate the degree to which each of 20 health issues is a problem in their own community, using a scale of “major problem,” “moderate problem,” “minor problem” or “no problem at all.” The following chart summarizes their responses; these findings are also outlined throughout this report, along with the qualitative input describing reasons for their concerns. (Note that these ratings alone do not establish priorities for this assessment, but rather are one of several data inputs considered for the prioritization process described earlier.)

Key Informants: Relative Position of Health Topics as Problems in the Community



Data Charts & Key Informant Input

The following sections present data from multiple sources, including the random-sample PRC Community Health Survey, public health and other existing data sets (secondary data), as well as qualitative input from the Online Key Informant Survey. Data indicators from these sources are intermingled and organized by health topic. To better understand the source data for specific indicators, please refer to the footnotes accompanying each chart.



Professional Research Consultants, Inc.

Community Characteristics

Population Characteristics

Land Area, Population Size & Density

Data from the US Census Bureau reveal the following statistics for our community relative to size, population, and density.

Total Population
(Estimated Population, 2011-2015)

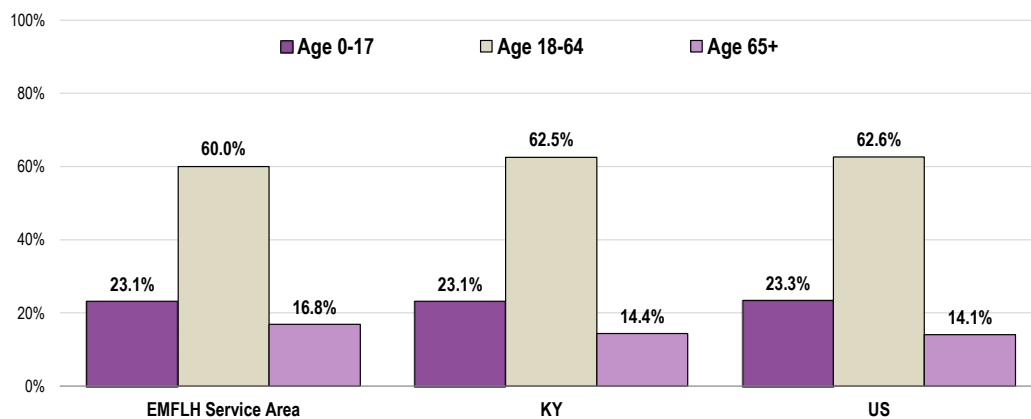
	Total Population	Total Land Area (Square Miles)	Population Density (Per Square Mile)
EMFLH Service Area	57,428	1,007.04	57.03
Kentucky	4,397,353	39,485.22	111.37
United States	316,515,021	3,532,070.45	89.61

Sources:
 • US Census Bureau American Community Survey 5-year estimates.
 • Retrieved March 2017 from Community Commons at <http://www.chna.org>.

Age

It is important to understand the age distribution of the population as different age groups have unique health needs which should be considered separately from others along the age spectrum.

Total Population by Age Groups, Percent
(2011-2015)

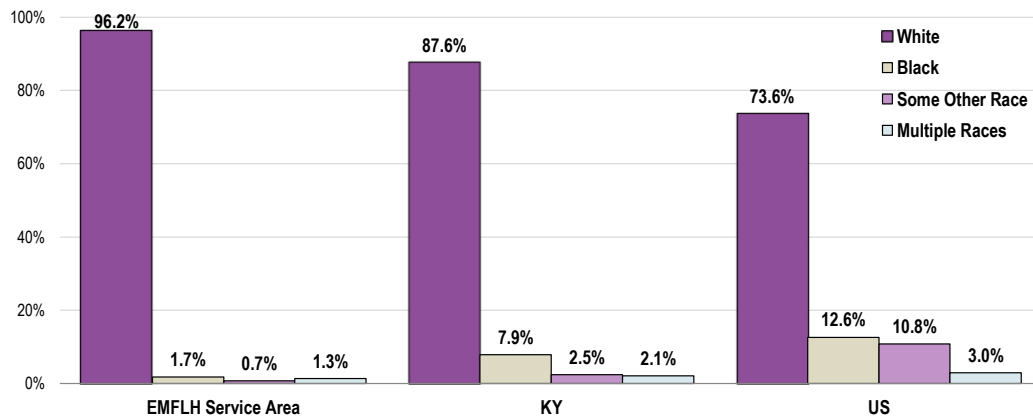


Sources:
 • US Census Bureau American Community Survey 5-year estimates.
 • Retrieved March 2017 from Community Commons at <http://www.chna.org>.

Race & Ethnicity

The following charts illustrate the racial and ethnic makeup of our community. Note that ethnicity (Hispanic or Latino) can be of any race.

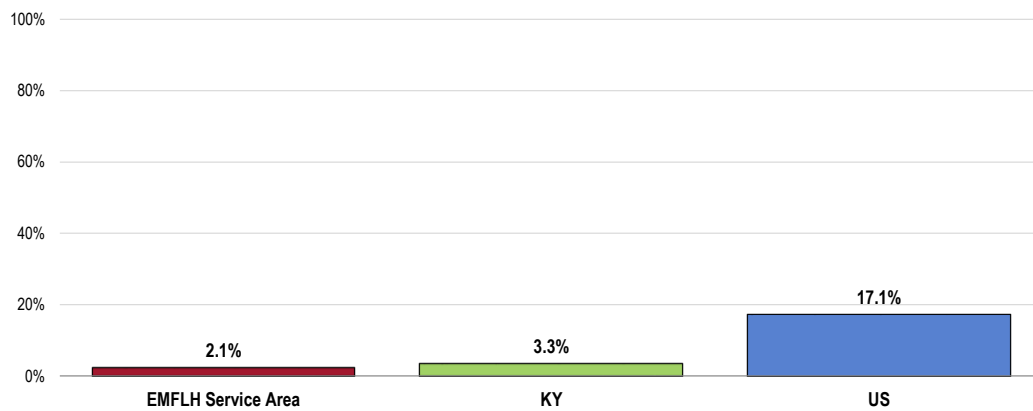
Total Population by Race Alone, Percent (2011-2015)



Sources:

- US Census Bureau American Community Survey 5-year estimates.
- Retrieved March 2017 from Community Commons at <http://www.chna.org>.

Hispanic Population (2011-2015)



Sources:

- US Census Bureau American Community Survey 5-year estimates.
- Retrieved March 2017 from Community Commons at <http://www.chna.org>.

 Notes:

- Origin can be viewed as the heritage, nationality group, lineage, or country of birth of the person or the person's parents or ancestors before their arrival in the United States. People who identify their origin as Hispanic, Latino, or Spanish may be of any race.

Social Determinants of Health

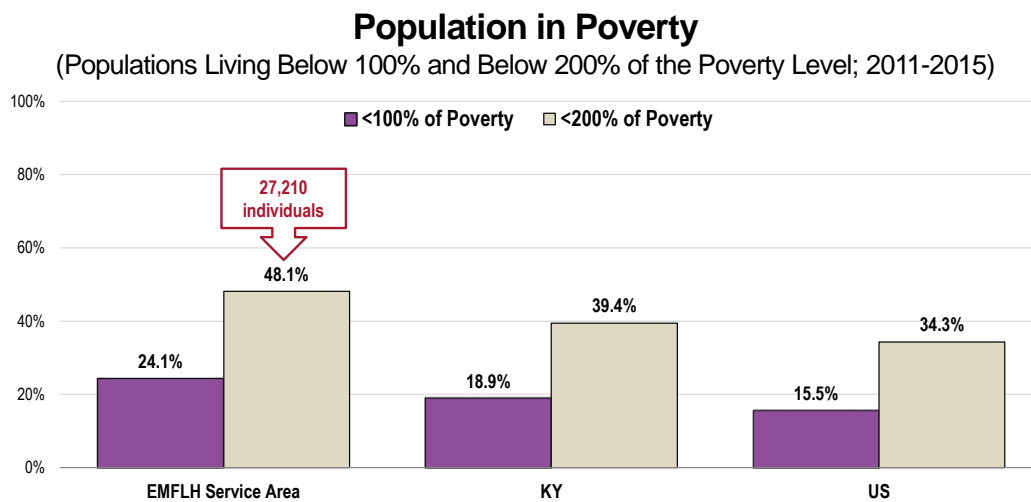
About Social Determinants

Health starts in our homes, schools, workplaces, neighborhoods, and communities. We know that taking care of ourselves by eating well and staying active, not smoking, getting the recommended immunizations and screening tests, and seeing a doctor when we are sick all influence our health. Our health is also determined in part by access to social and economic opportunities; the resources and supports available in our homes, neighborhoods, and communities; the quality of our schooling; the safety of our workplaces; the cleanliness of our water, food, and air; and the nature of our social interactions and relationships. The conditions in which we live explain in part why some Americans are healthier than others and why Americans more generally are not as healthy as they could be.

- Healthy People 2020 (www.healthypeople.gov)

Poverty

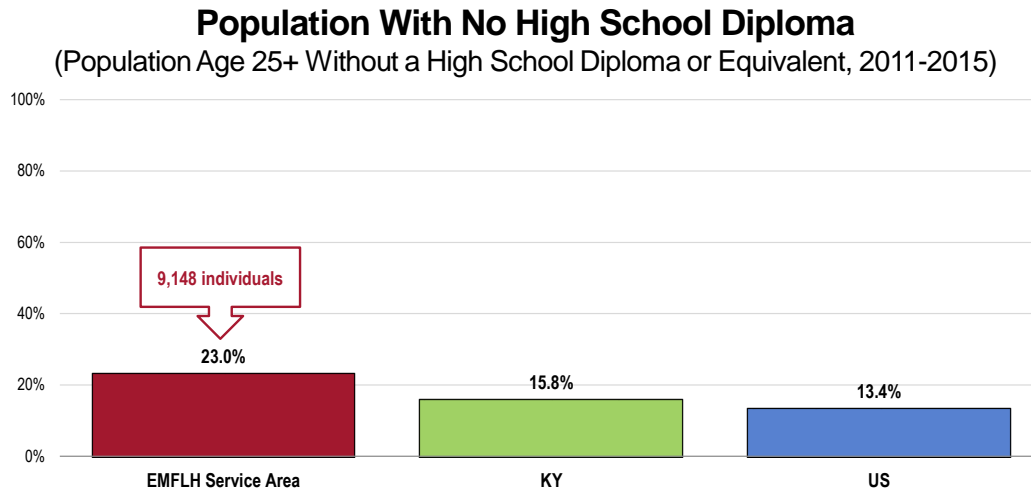
The following chart outlines the proportion of our population below the federal poverty threshold, as well as below 200% of the federal poverty level, in comparison to state and national proportions.



- Sources:
- US Census Bureau American Community Survey 5-year estimates.
 - Retrieved March 2017 from Community Commons at <http://www.chna.org>.
- Notes:
- Poverty is considered a key driver of health status. This indicator is relevant because poverty creates barriers to access including health services, healthy food, and other necessities that contribute to poor health status.

Education

Education levels are reflected in the proportion of our population without a high school diploma:



- Sources:
- US Census Bureau American Community Survey 5-year estimates.
 - Retrieved March 2017 from Community Commons at <http://www.chna.org>.
- Notes:
- This indicator is relevant because educational attainment is linked to positive health outcomes.

General Health Status

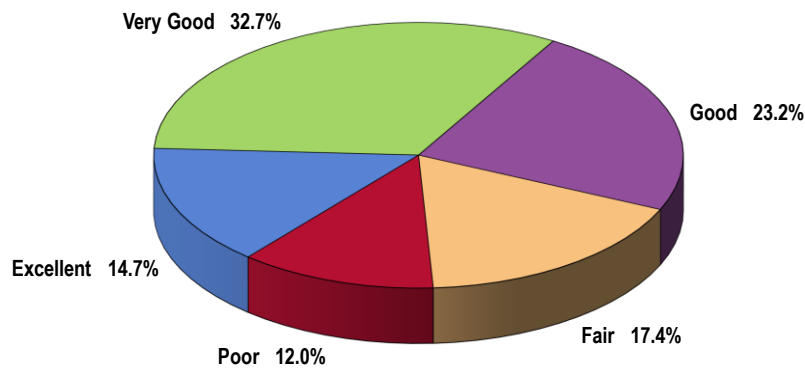
Overall Health Status

Self-Reported Health Status

The initial inquiry of the PRC Community Health Survey asked respondents the following:

“Would you say that in general your health is: excellent, very good, good, fair or poor?”

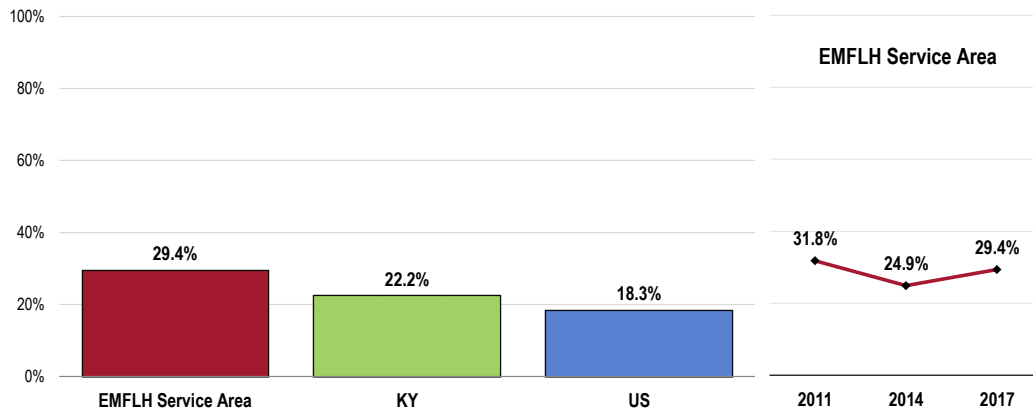
Self-Reported Health Status
(EMFLH Service Area, 2017)



Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 5]
Notes: • Asked of all respondents.

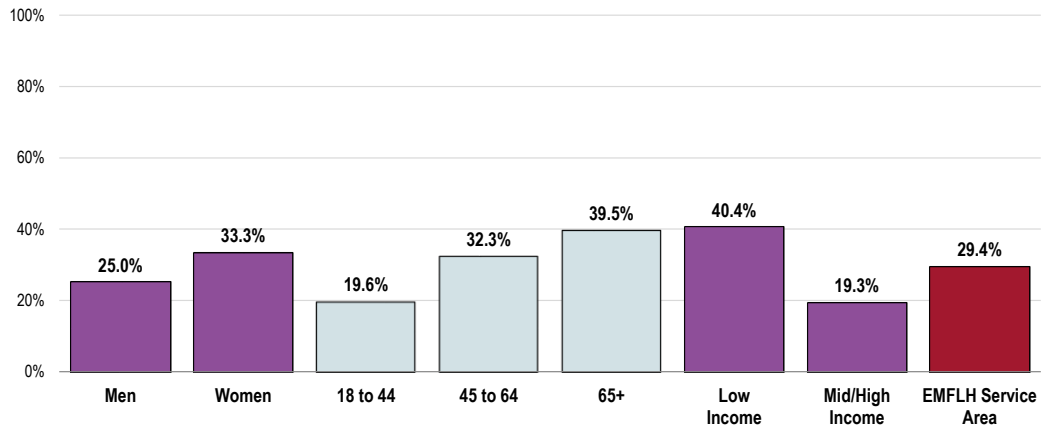
The following charts further detail “fair/poor” overall health responses in EMFLH Service Area in comparison to benchmark data, as well as by basic demographic characteristics (namely by gender, age groupings, and income [based on poverty status]).

Experience “Fair” or “Poor” Overall Health



Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 5]
• Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2015 KY data.
• 2015 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.

Experience “Fair” or “Poor” Overall Health (EMFLH Service Area, 2017)



Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 5]

Notes: • Asked of all respondents.

• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Activity Limitations

About Disability & Health

An individual can get a disabling impairment or chronic condition at any point in life. Compared with people without disabilities, people with disabilities are more likely to:

- Experience difficulties or delays in getting the health care they need.
- Not have had an annual dental visit.
- Not have had a mammogram in past 2 years.
- Not have had a Pap test within the past 3 years.
- Not engage in fitness activities.
- Use tobacco.
- Be overweight or obese.
- Have high blood pressure.
- Experience symptoms of psychological distress.
- Receive less social-emotional support.
- Have lower employment rates.

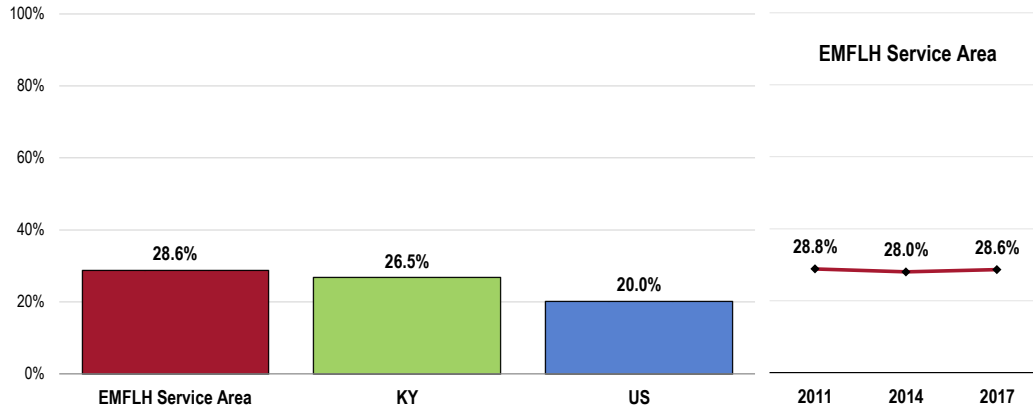
There are many social and physical factors that influence the health of people with disabilities. The following three areas for public health action have been identified, using the International Classification of Functioning, Disability, and Health (ICF) and the three World Health Organization (WHO) principles of action for addressing health determinants.

- **Improve the conditions of daily life** by: encouraging communities to be accessible so all can live in, move through, and interact with their environment; encouraging community living; and removing barriers in the environment using both physical universal design concepts and operational policy shifts.
- **Address the inequitable distribution of resources among people with disabilities and those without disabilities** by increasing: appropriate health care for people with disabilities; education and work opportunities; social participation; and access to needed technologies and assistive supports.
- **Expand the knowledge base and raise awareness about determinants of health for people with disabilities** by increasing: the inclusion of people with disabilities in public health data collection efforts across the lifespan; the inclusion of people with disabilities in health promotion activities; and the expansion of disability and health training opportunities for public health and health care professionals.

- Healthy People 2020 (www.healthypeople.gov)

“Are you limited in any way in any activities because of physical, mental or emotional problems?”

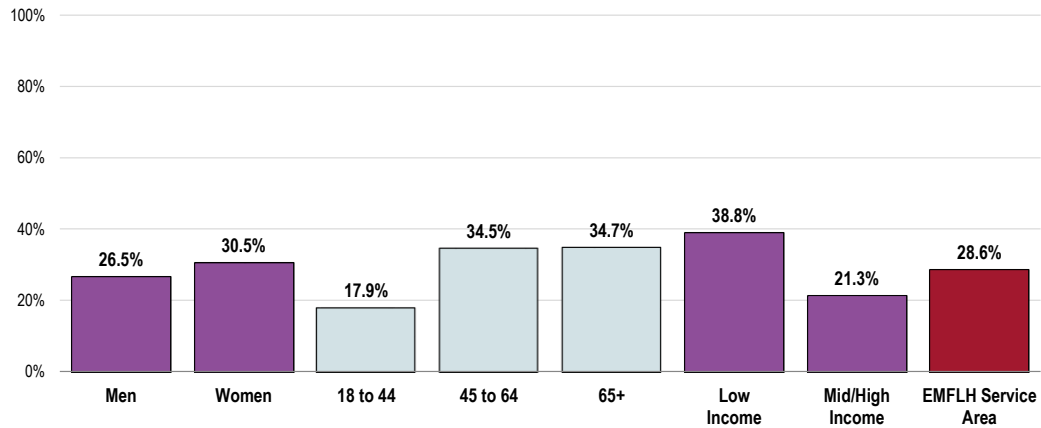
Limited in Activities in Some Way Due to a Physical, Mental or Emotional Problem



Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 128]
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2015 KY data.
 • 2015 PRC National Health Survey, Professional Research Consultants, Inc.

Notes: • Asked of all respondents.

Limited in Activities in Some Way Due to a Physical, Mental or Emotional Problem (EMFLH Service Area, 2017)

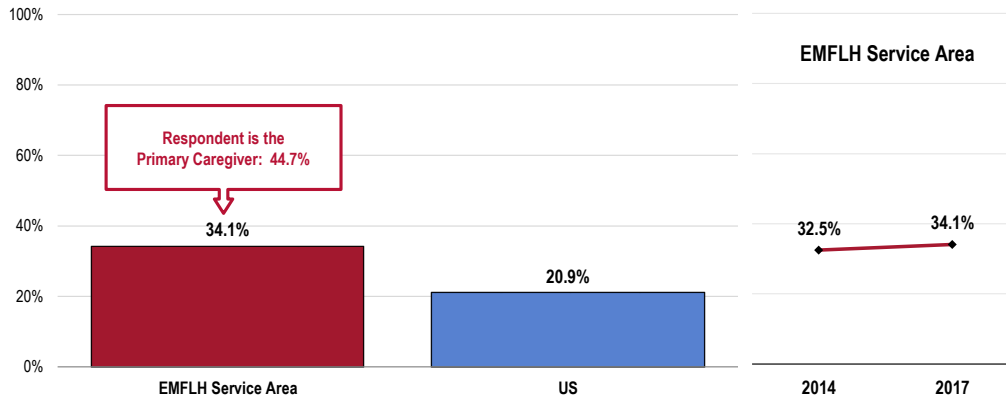


Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 128]
 Notes: • Asked of all respondents.
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Caregiving

“People may provide regular care or assistance to a friend or family member who has a health problem, long-term illness, or disability. During the past 30 days, did you provide any such care or assistance to a friend or family member?”

Act as Caregiver to a Friend or Relative with a Health Problem, Long-Term Illness, or Disability



Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 130-131]
 • 2015 PRC National Health Survey, Professional Research Consultants, Inc.
 Notes: • Asked of all respondents.

Mental Health

About Mental Health & Mental Disorders

Mental health is a state of successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with challenges. Mental health is essential to personal well-being, family and interpersonal relationships, and the ability to contribute to community or society. Mental disorders are health conditions that are characterized by alterations in thinking, mood, and/or behavior that are associated with distress and/or impaired functioning. Mental disorders contribute to a host of problems that may include disability, pain, or death. Mental illness is the term that refers collectively to all diagnosable mental disorders. Mental disorders are among the most common causes of disability. The resulting disease burden of mental illness is among the highest of all diseases.

Mental health and physical health are closely connected. Mental health plays a major role in people's ability to maintain good physical health. Mental illnesses, such as depression and anxiety, affect people's ability to participate in health-promoting behaviors. In turn, problems with physical health, such as chronic diseases, can have a serious impact on mental health and decrease a person's ability to participate in treatment and recovery.

The existing model for understanding mental health and mental disorders emphasizes the interaction of social, environmental, and genetic factors throughout the lifespan. In behavioral health, researchers identify: **risk factors**, which predispose individuals to mental illness; and **protective factors**, which protect them from developing mental disorders. Researchers now know that the prevention of mental, emotional, and behavioral (MEB) disorders is inherently interdisciplinary and draws on a variety of different strategies. Over the past 20 years, research on the prevention of mental disorders has progressed. The major areas of progress include evidence that:

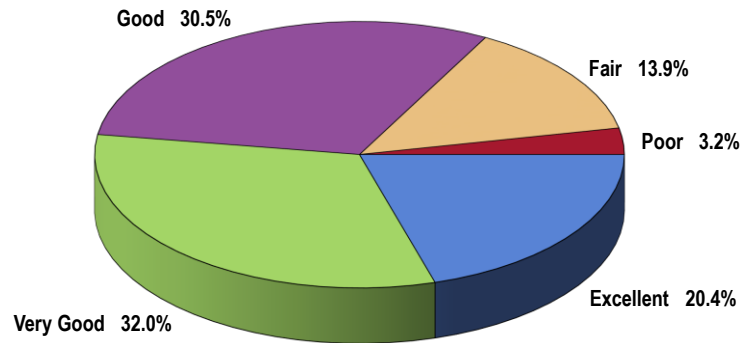
- MEB disorders are common and begin early in life.
- The greatest opportunity for prevention is among young people.
- There are multiyear effects of multiple preventive interventions on reducing substance abuse, conduct disorder, antisocial behavior, aggression, and child maltreatment.
- The incidence of depression among pregnant women and adolescents can be reduced.
- School-based violence prevention can reduce the base rate of aggressive problems in an average school by 25 to 33%.
- There are potential indicated preventive interventions for schizophrenia.
- Improving family functioning and positive parenting can have positive outcomes on mental health and can reduce poverty-related risk.
- School-based preventive interventions aimed at improving social and emotional outcomes can also improve academic outcomes.
- Interventions targeting families dealing with adversities, such as parental depression or divorce, can be effective in reducing risk for depression in children and increasing effective parenting.
- Some preventive interventions have benefits that exceed costs, with the available evidence strongest for early childhood interventions.
- Implementation is complex, it is important that interventions be relevant to the target audiences.
- In addition to advancements in the prevention of mental disorders, there continues to be steady progress in treating mental disorders as new drugs and stronger evidence-based outcomes become available.

- Healthy People 2020 (www.healthypeople.gov)

Self-Reported Mental Health Status

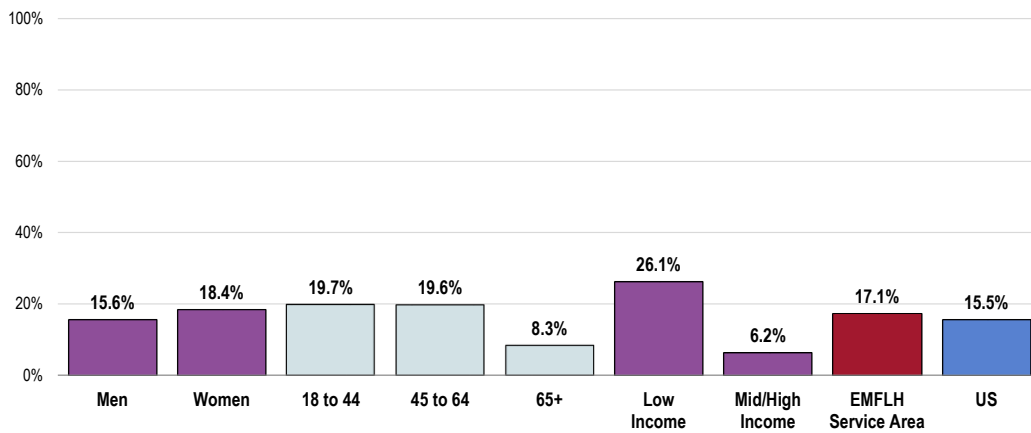
“Now thinking about your mental health, which includes stress, depression and problems with emotions, would you say that, in general, your mental health is: excellent, very good, good, fair or poor?”

Self-Reported Mental Health Status
(EMFLH Service Area, 2017)



Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 116]
Notes: • Asked of all respondents.

Experience “Fair” or “Poor” Mental Health
(EMFLH Service Area, 2017)

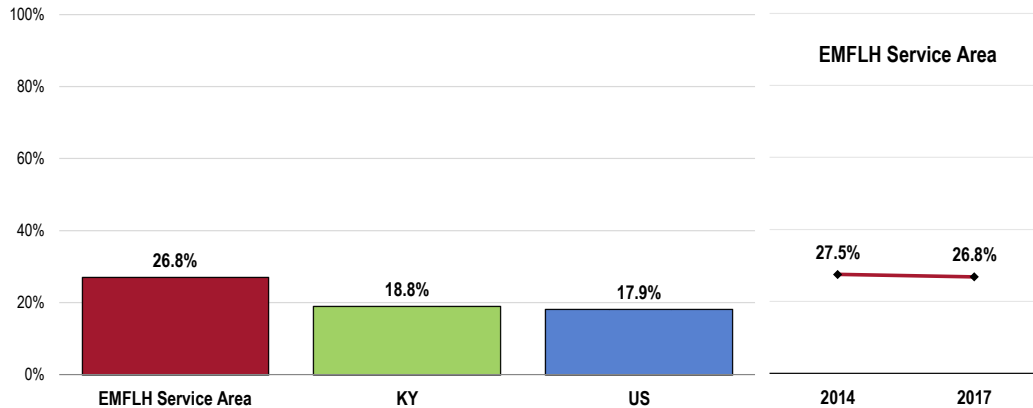


Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 116]
Notes: • Asked of all respondents.
• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Depression

Diagnosed Depression: “Has a doctor or other healthcare provider ever told you that you have a depressive disorder, including depression, major depression, dysthymia, or minor depression?”

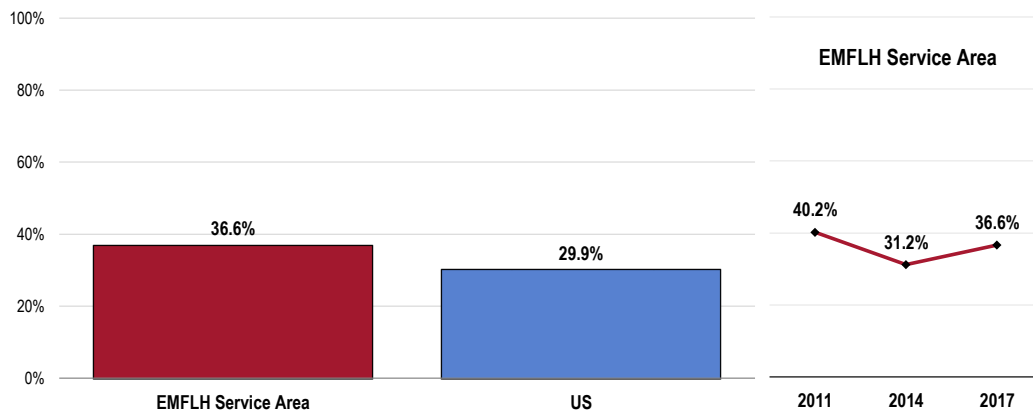
Have Been Diagnosed With a Depressive Disorder



- Sources:
- 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 119]
 - Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2015 KY data.
 - 2015 PRC National Health Survey, Professional Research Consultants, Inc.
- Notes:
- Asked of all respondents.
 - Depressive disorders include depression, major depression, dysthymia, or minor depression.

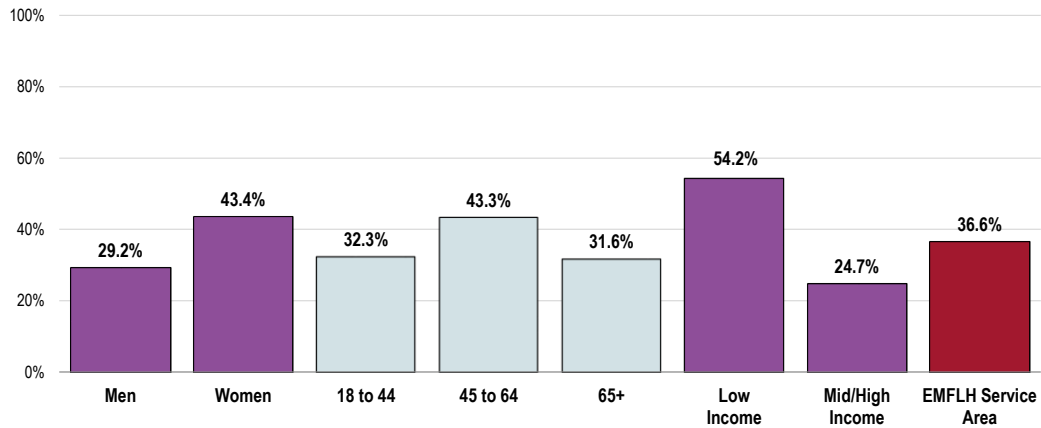
Symptoms of Chronic Depression: “Have you had two years or more in your life when you felt depressed or sad most days, even if you felt okay sometimes?”

Have Experienced Symptoms of Chronic Depression



- Sources:
- 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 117]
 - 2015 PRC National Health Survey, Professional Research Consultants, Inc.
- Notes:
- Asked of all respondents.
 - Chronic depression includes periods of two or more years during which the respondent felt depressed or sad on most days, even if (s)he felt okay sometimes.

Have Experienced Symptoms of Chronic Depression (EMFLH Service Area, 2017)

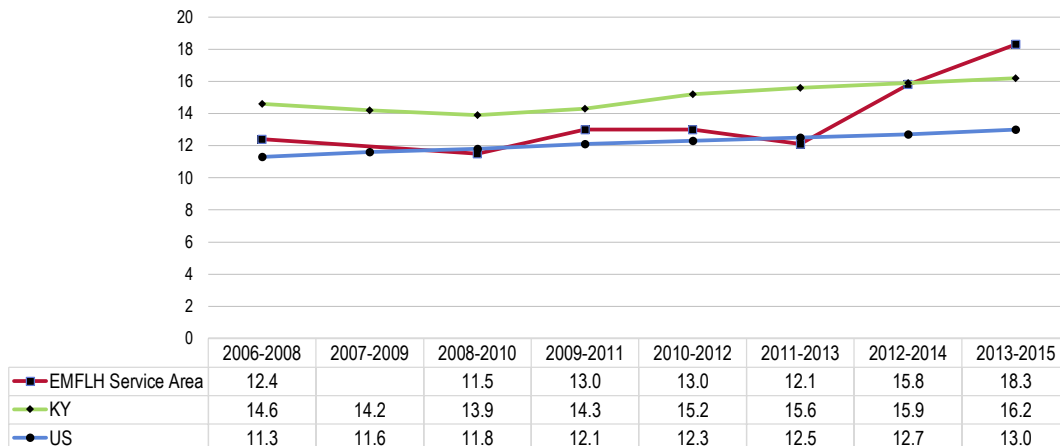


Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 117]
 Notes: • Asked of all respondents.
 • Chronic depression includes periods of two or more years during which the respondent felt depressed or sad on most days, even if (s)he felt okay sometimes.
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Suicide

The following chart outlines the most current age-adjusted mortality rates attributed to suicide in our population. (Refer to "Leading Causes of Death" for an explanation of the use of age-adjusting for these rates.)

Suicide: Age-Adjusted Mortality Trends (Annual Average Deaths per 100,000 Population) Healthy People 2020 Target = 10.2 or Lower

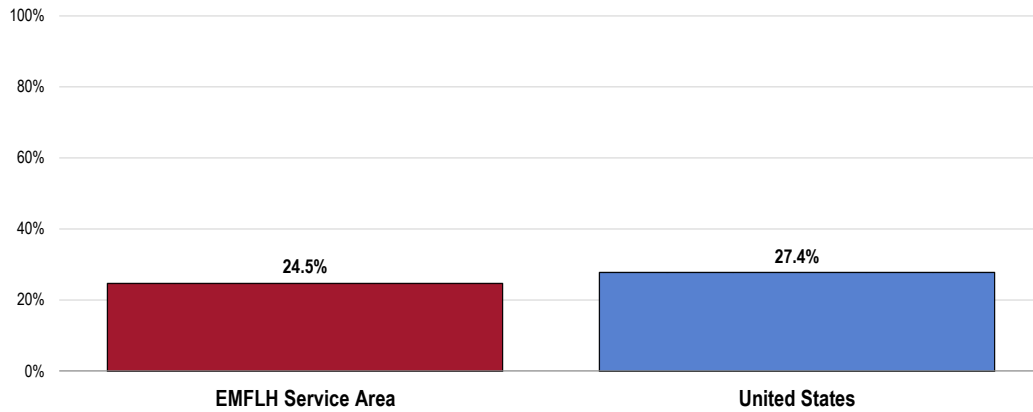


Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted March 2017.
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective MHMD-1]
 Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
 • Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Mental Health Treatment

“Have you ever sought help from a professional for a mental or emotional problem?”

Ever Sought Help for a Mental or Emotional Problem



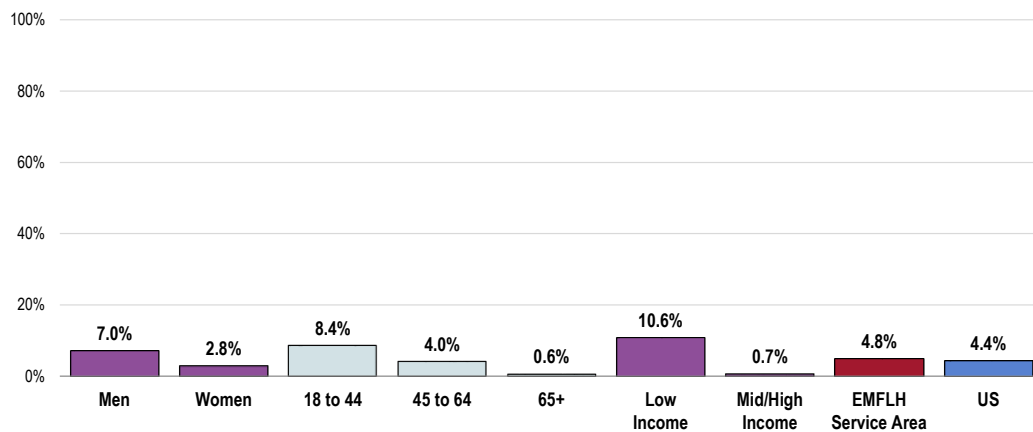
Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 121]

• 2015 PRC National Health Survey, Professional Research Consultants, Inc.

Notes: • Reflects the total sample of respondents.

“Was there a time in the PAST 12 MONTHS when you needed mental health services but were not able to get them?”

Unable to Get Mental Health Services When Needed in the Past Year (EMFLH Service Area, 2017)



Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 122]

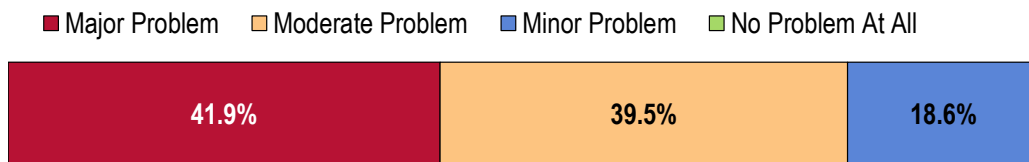
Notes: • Asked of all respondents.

• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Key Informant Input: Mental Health

This chart outlines key informants' perceptions of the severity of *Mental Health* as a problem in the community:

Perceptions of Mental Health as a Problem in the Community (Key Informants, 2017)



Sources: ● PRC Online Key Informant Survey, Professional Research Consultants, Inc.
Notes: ● Asked of all respondents.

Challenges

Among those rating this issue as a “major problem,” the following represent what key informants see as the main challenges for persons with mental illness:

Access to Care/Services

We do not have a clear mental health network. – Community Leader

When families/students agree to receive assistance to address mental health issues/needs, we do not have systems of support in place. Our referrals are always to outside the community agencies. And many times, the facilities are overcrowded or the service provider is not taking new clients. If residential treatment is needed, many of our families are turned away, and families/students go untreated. – Community Leader

No long-term support facility. – Community Leader

Access to extended mental health care. – Community Leader

We are extremely limited in available treatment centers- not only in our region, but in Kentucky. I think there are options in Louisville, Lexington and E-town, but outside of that, I am not aware of any true treatment options for people with mental illness. – Community Leader

Access to services. – Community Leader

There are very limited amount of resources in this area to help with mental illness, especially among school-aged children. – Community Leader

Locally provided mental health counseling no longer available in Mercer County. Bluegrass.org closed their office. – Public Health Representative

Lack of Providers

Lack of affordable, qualified mental health professionals for outpatient and inpatient care. – Public Health Representative

Lack of providers. – Public Health Representative

Access to care, such as a psychiatrist. – Physician

Co-Occurrences

Drug addiction and the break-up of the family unit. – Community Leader

Social-economic well-being, leading to drugs and mental health issues. – Community Leader

Prevalence/Incidence

Number of cases I hear about. – Social Services Provider

Denial/Stigma

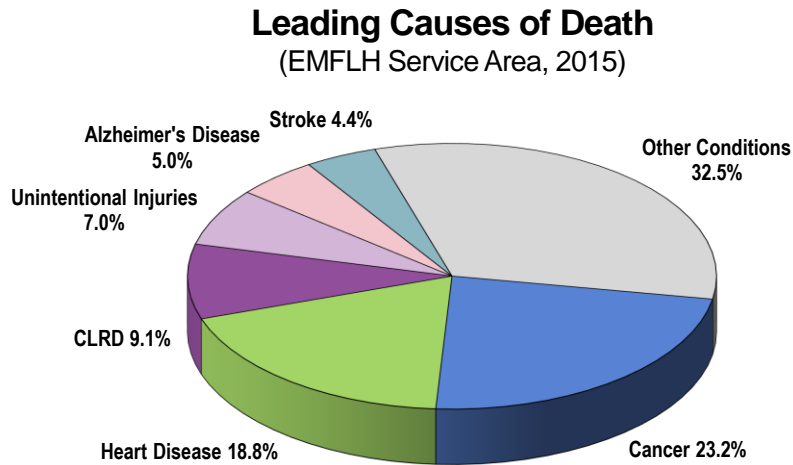
Stigma of treatment. No readily available treatment. Misunderstanding about the nature of mental illness. – Community Leader

Death, Disease & Chronic Conditions

Leading Causes of Death

Distribution of Deaths by Cause

Cancers and cardiovascular disease (heart disease and stroke) are leading causes of death in the community.



- Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted March 2017.
- Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
 - CLRD is chronic lower respiratory disease.

Age-Adjusted Death Rates for Selected Causes

In order to compare mortality in the region with other localities (in this case, the state and the United States), it is necessary to look at *rates* of death — these are figures which represent the number of deaths in relation to the population size (such as deaths per 100,000 population, as is used here).

Furthermore, in order to compare localities without undue bias toward younger or older populations, the common convention is to adjust the data to some common baseline age distribution. Use of these “age-adjusted” rates provides the most valuable means of gauging mortality against benchmark data, as well as *Healthy People 2020* targets.

The following chart outlines annual average age-adjusted death rates per 100,000 population for selected causes of death in the area. (For infant mortality data, see *Birth Outcomes & Risks* in the **Births** section of this report.)

Age-Adjusted Death Rates for Selected Causes (2013-2015 Deaths per 100,000 Population)

	EMFLH Service Area	KY	US	HP2020
Malignant Neoplasms (Cancers)	214.2	198.0	161.0	161.4
Diseases of the Heart	182.0	200.6	168.4	156.9*
Chronic Lower Respiratory Disease (CLRD)	76.9	64.2	41.4	n/a
Unintentional Injuries	62.9	60.0	41.0	36.4
Alzheimer's Disease	46.7	32.8	26.1	n/a
Cerebrovascular Disease (Stroke)	35.8	41.4	36.8	34.8
Pneumonia/Influenza	23.6	19.7	15.4	n/a
Motor Vehicle Deaths	22.7	15.7	10.6	12.4
Drug-Induced	20.2	27.2	15.8	11.3
Kidney Disease	20.1	19.9	13.3	n/a
Diabetes Mellitus	19.7	25.2	21.1	20.5*
Intentional Self-Harm (Suicide)	18.3	16.2	13.0	10.2
Firearm-Related	14.0	14.3	10.6	9.3
Cirrhosis/Liver Disease	11.7	11.6	10.5	8.2

Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted March 2017.

• US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov>.

Note: • Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population and coded using ICD-10 codes.

• *The Healthy People 2020 Heart Disease target is adjusted to account for all diseases of the heart; the Diabetes target is adjusted to reflect only diabetes mellitus-coded deaths.

Cardiovascular Disease

About Heart Disease & Stroke

Heart disease is the leading cause of death in the United States, with stroke following as the third leading cause. Together, heart disease and stroke are among the most widespread and costly health problems facing the nation today, accounting for more than \$500 billion in healthcare expenditures and related expenses in 2010 alone. Fortunately, they are also among the most preventable.

The leading modifiable (controllable) risk factors for heart disease and stroke are:

- High blood pressure
- High cholesterol
- Cigarette smoking
- Diabetes
- Poor diet and physical inactivity
- Overweight and obesity

The risk of Americans developing and dying from cardiovascular disease would be substantially reduced if major improvements were made across the US population in diet and physical activity, control of high blood pressure and cholesterol, smoking cessation, and appropriate aspirin use.

The burden of cardiovascular disease is disproportionately distributed across the population. There are significant disparities in the following based on gender, age, race/ethnicity, geographic area, and socioeconomic status:

- Prevalence of risk factors
- Access to treatment
- Appropriate and timely treatment
- Treatment outcomes
- Mortality

Disease does not occur in isolation, and cardiovascular disease is no exception. Cardiovascular health is significantly influenced by the physical, social, and political environment, including: maternal and child health; access to educational opportunities; availability of healthy foods, physical education, and extracurricular activities in schools; opportunities for physical activity, including access to safe and walkable communities; access to healthy foods; quality of working conditions and worksite health; availability of community support and resources; and access to affordable, quality healthcare.

- Healthy People 2020 (www.healthypeople.gov)

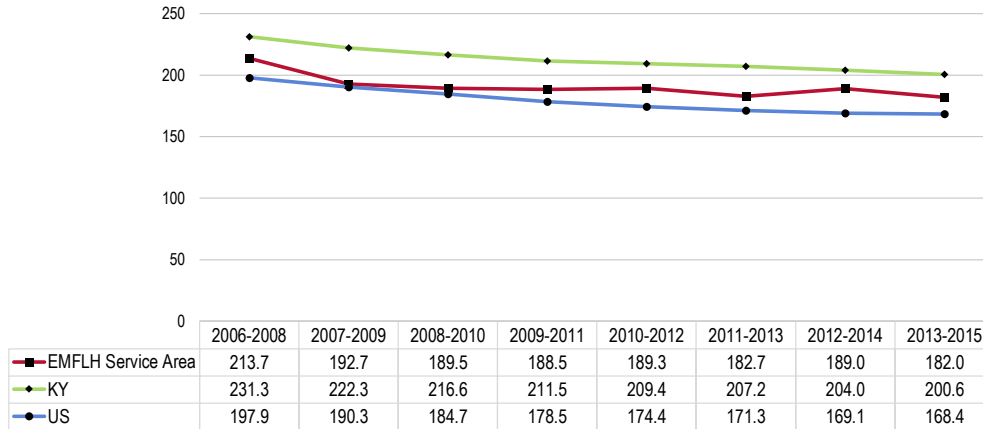
Age-Adjusted Heart Disease & Stroke Deaths

The greatest share of cardiovascular deaths is attributed to heart disease. The following charts outline age-adjusted mortality rates for heart disease and for stroke in our community.

Heart Disease: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)

Healthy People 2020 Target = 156.9 or Lower (Adjusted)

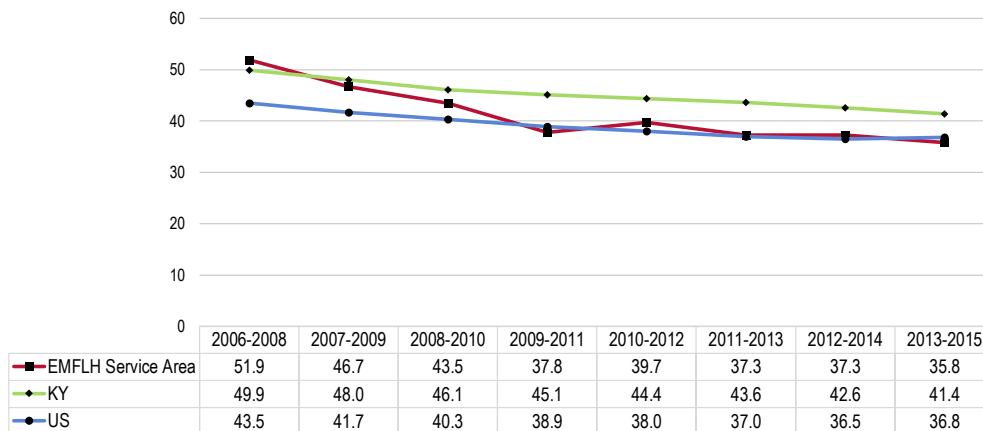


- Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted March 2017.
 - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective HDS-2]
- Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
 - Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.
 - The Healthy People 2020 Heart Disease target is adjusted to account for all diseases of the heart.

Stroke: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)

Healthy People 2020 Target = 34.8 or Lower



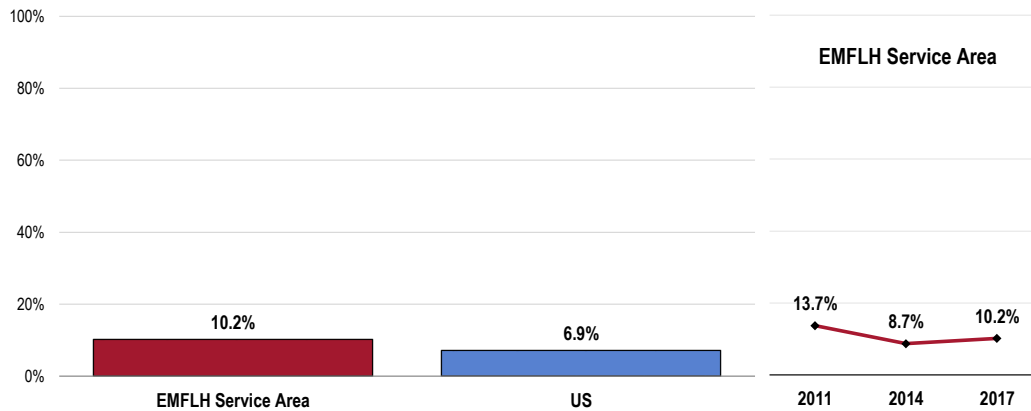
- Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted March 2017.
 - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective HDS-3]
- Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
 - Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Prevalence of Heart Disease & Stroke

“Has a doctor, nurse or other health professional ever told you that you had: A heart attack, also called a myocardial infarction; or angina or coronary heart disease?” (Heart disease prevalence below is a calculated prevalence that includes those responding affirmatively to either.)

“Has a doctor, nurse or other health professional ever told you that you had a stroke?”

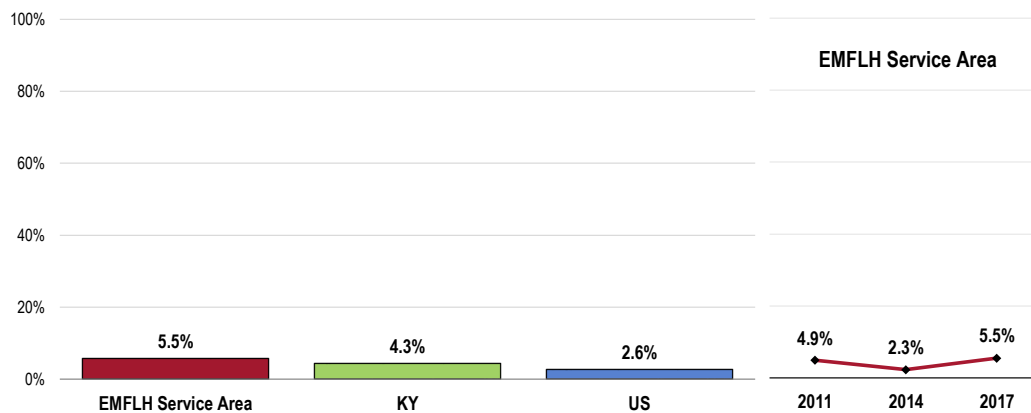
Prevalence of Heart Disease



Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 146]
 • 2015 PRC National Health Survey, Professional Research Consultants, Inc.

Notes: • Asked of all respondents.
 • Includes diagnoses of heart attack, angina or coronary heart disease.

Prevalence of Stroke



Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 35]
 • 2015 PRC National Health Survey, Professional Research Consultants, Inc.
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2015 KY data.

Notes: • Asked of all respondents.

Cardiovascular Risk Factors

About Cardiovascular Risk

Controlling risk factors for heart disease and stroke remains a challenge. High blood pressure and cholesterol are still major contributors to the national epidemic of cardiovascular disease. High blood pressure affects approximately 1 in 3 adults in the United States, and more than half of Americans with high blood pressure do not have it under control. High sodium intake is a known risk factor for high blood pressure and heart disease, yet about 90% of American adults exceed their recommendation for sodium intake.

- Healthy People 2020 (www.healthypeople.gov)

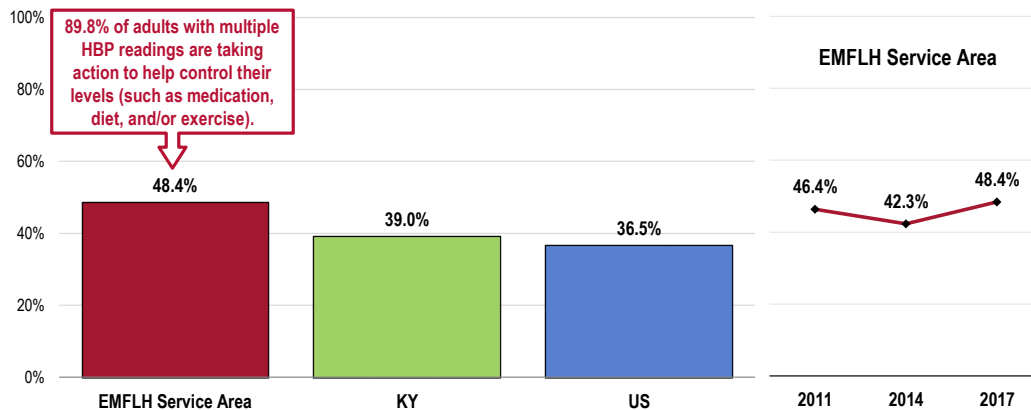
High Blood Pressure & Cholesterol Prevalence

“Have you ever been told by a doctor, nurse or other health care professional that you had high blood pressure?”

“Blood cholesterol is a fatty substance found in the blood. Have you ever been told by a doctor, nurse, or other health care professional that your blood cholesterol is high?”

Prevalence of High Blood Pressure

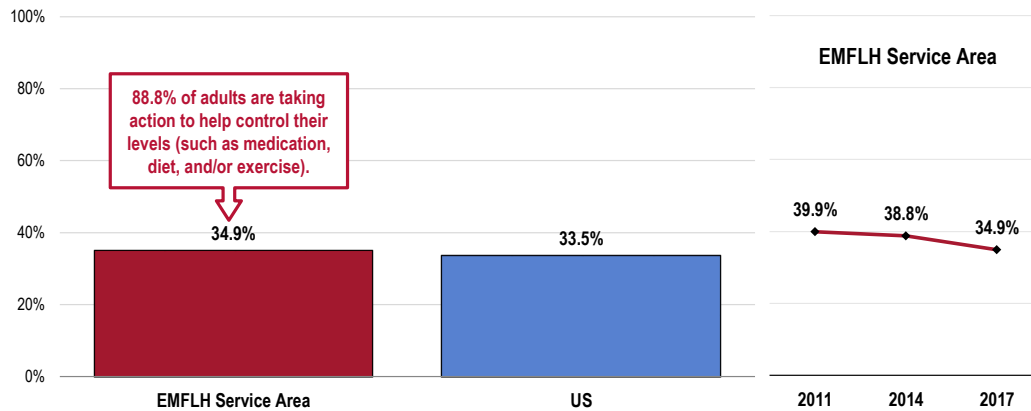
Healthy People 2020 Target = 26.9% or Lower



- Sources:
- 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 43, 147]
 - Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2015 KY data.
 - 2015 PRC National Health Survey, Professional Research Consultants, Inc.
 - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective HDS-5.1]
- Notes:
- Asked of all respondents.

Prevalence of High Blood Cholesterol

Healthy People 2020 Target = 13.5% or Lower



Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 46, 148]
 • 2015 PRC National Health Survey, Professional Research Consultants, Inc.
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective HDS-7]
 Notes: • Asked of all respondents.

About Cardiovascular Risk

Individual level risk factors which put people at increased risk for cardiovascular diseases include:

- High Blood Pressure
- High Blood Cholesterol
- Tobacco Use
- Physical Inactivity
- Poor Nutrition
- Overweight/Obesity
- Diabetes
- National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention

Three health-related behaviors contribute markedly to cardiovascular disease:

Poor nutrition. People who are overweight have a higher risk for cardiovascular disease. Almost 60% of adults are overweight or obese. To maintain a proper body weight, experts recommend a well-balanced diet which is low in fat and high in fiber, accompanied by regular exercise.

Lack of physical activity. People who are not physically active have twice the risk for heart disease of those who are active. More than half of adults do not achieve recommended levels of physical activity.

Tobacco use. Smokers have twice the risk for heart attack of nonsmokers. Nearly one-fifth of all deaths from cardiovascular disease, or about 190,000 deaths a year nationally, are smoking-related. Every day, more than 3,000 young people become daily smokers in the US.

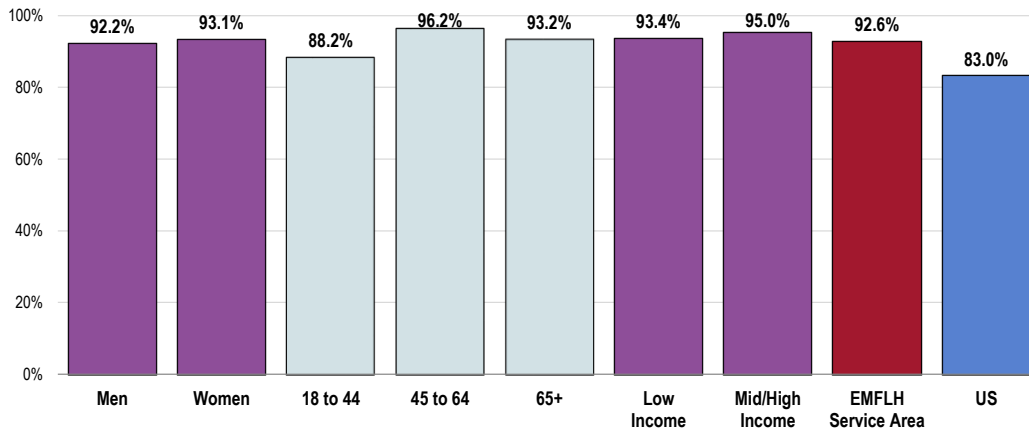
Modifying these behaviors is critical both for preventing and for controlling cardiovascular disease. Other steps that adults who have cardiovascular disease should take to reduce their risk of death and disability include adhering to treatment for high blood pressure and cholesterol, using aspirin as appropriate, and learning the symptoms of heart attack and stroke.

- National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention

Total Cardiovascular Risk

The following chart reflects the percentage of adults in the EMFLH Service Area who report one or more of the following: being overweight; smoking cigarettes; being physically inactive; or having high blood pressure or cholesterol. See also *Nutrition, Physical Activity & Weight* and *Tobacco Use* in the **Modifiable Health Risk** section of this report.

Present One or More Cardiovascular Risks or Behaviors
(EMFLH Service Area, 2017)

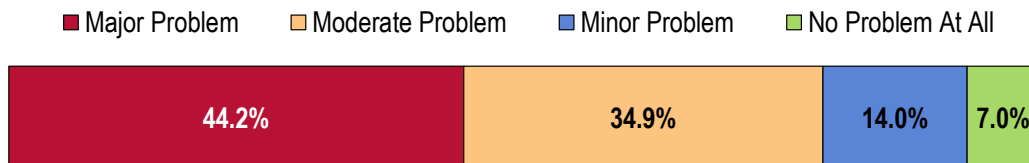


Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 149]
 Notes: • Asked of all respondents.
 • Cardiovascular risk is defined as exhibiting one or more of the following: 1) no leisure-time physical activity; 2) regular/occasional cigarette smoking; 3) hypertension; 4) high blood cholesterol; and/or 5) being overweight/obese.
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Key Informant Input: Heart Disease & Stroke

The following chart outlines key informants' perceptions of the severity of *Heart Disease & Stroke* as a problem in the community:

Perceptions of Heart Disease and Stroke as a Problem in the Community
(Key Informants, 2017)



Sources: • PRC Online Key Informant Survey, Professional Research Consultants, Inc.
 Notes: • Asked of all respondents.

Top Concerns

Among those rating this issue as a “major problem,” reasons related to the following:

Lifestyle

Lifestyle is a major contributor to this disease, and folks either do not have the information or refuse to accept it. – Community Leader

Lack of healthy diet and physical activity. – Public Health Representative

Exercise, dietary and smoking habits. And to some degree, stress. – Community Leader

Diet, lack of exercise and genes. – Community Leader

Obesity and drug abuse. – Community Leader

Obesity, poor diet, poor exercise and high blood pressure. – Physician

Prevalence/Incidence

Most of the folks I visit in the hospital are dealing with some form of heart disease and/or stroke. – Social Services Provider

People are having heart attacks and heart-related issues. – Community Leader

We have the best heart doctor in Kentucky at EMRMC. – Community Leader

Many deaths due to these factors. – Community Leader

Large numbers associated with both. – Social Services Provider

Aging Population

Elderly population and tobacco use. – Community Leader

Tobacco Use

Smoking and diet. – Community Leader

Cancer

About Cancer

Continued advances in cancer research, detection, and treatment have resulted in a decline in both incidence and death rates for all cancers. Among people who develop cancer, more than half will be alive in five years. Yet, cancer remains a leading cause of death in the United States, second only to heart disease.

Many cancers are preventable by reducing risk factors such as: use of tobacco products; physical inactivity and poor nutrition; obesity; and ultraviolet light exposure. Other cancers can be prevented by getting vaccinated against human papillomavirus and hepatitis B virus. In the past decade, overweight and obesity have emerged as new risk factors for developing certain cancers, including colorectal, breast, uterine corpus (endometrial), and kidney cancers. The impact of the current weight trends on cancer incidence will not be fully known for several decades. Continued focus on preventing weight gain will lead to lower rates of cancer and many chronic diseases.

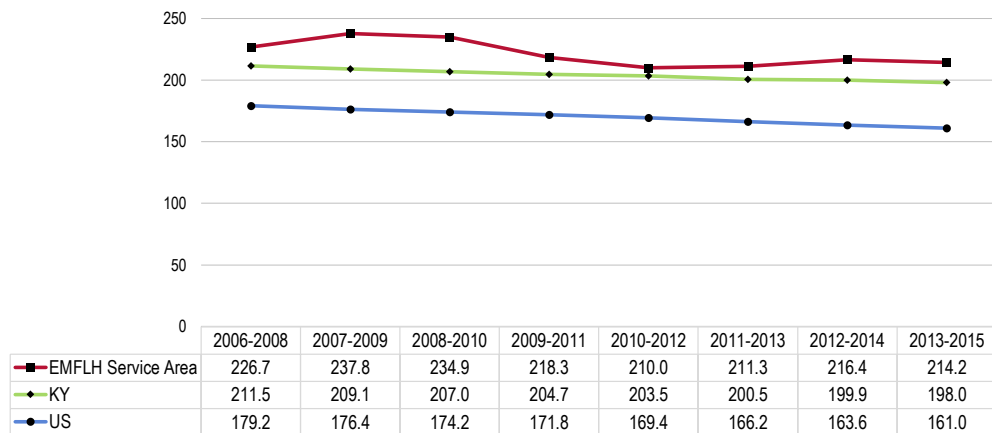
Screening is effective in identifying some types of cancers (see US Preventive Services Task Force [USPSTF] recommendations), including:

- Breast cancer (using mammography)
- Cervical cancer (using Pap tests)
- Colorectal cancer (using fecal occult blood testing, sigmoidoscopy, or colonoscopy)
- Healthy People 2020 (www.healthypeople.gov)

Age-Adjusted Cancer Deaths

The following chart illustrates age-adjusted cancer mortality (all types) in EMFLH Service Area.

Cancer: Age-Adjusted Mortality Trends
 (Annual Average Deaths per 100,000 Population)
Healthy People 2020 Target = 161.4 or Lower



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted March 2017.
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective C-1]
 Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
 • Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Lung cancer is by far the leading cause of cancer deaths in the area. Other leading sites include breast cancer among women and colorectal cancer (both genders). Prostate cancer rates are unavailable for the three-county area.

Age-Adjusted Cancer Death Rates by Site
(2013-2015 Annual Average Deaths per 100,000 Population)

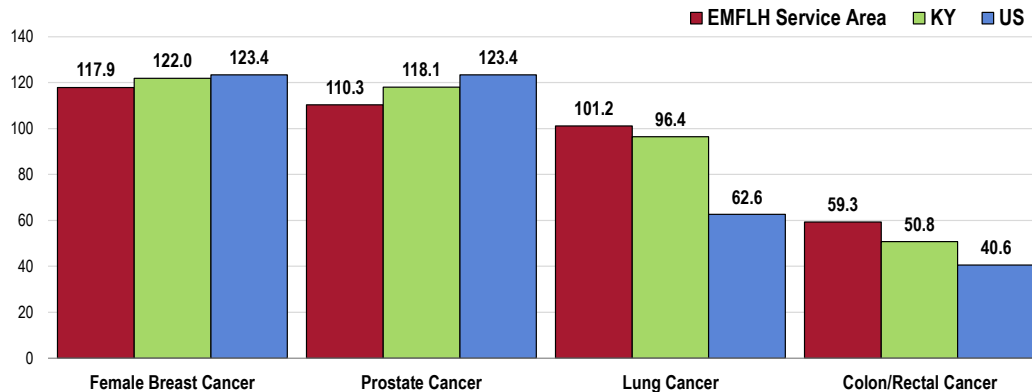
	EMFLH Service Area	KY	US	HP2020
ALL CANCERS	214.2	198.0	161.0	161.4
Lung Cancer	86.8	66.9	42.0	45.5
Prostate Cancer	n/a	19.0	19.0	21.8
Female Breast Cancer	25.0	21.0	20.6	20.7
Colorectal Cancer	19.5	17.1	14.4	14.5

Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted March 2017.
• US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov>

Cancer Incidence

Incidence rates (or case rates) reflect the number of newly diagnosed cases in a given population in a given year, regardless of outcome. They are usually expressed as cases per 100,000 population per year. Here, these rates are also age-adjusted.

Cancer Incidence Rates by Site
(Annual Average Age-Adjusted Incidence per 100,000 Population, 2009-2013)



Sources: • State Cancer Profiles.
• Retrieved March 2017 from Community Commons at <http://www.chna.org>.
Notes: • This indicator reports the age adjusted incidence rate (cases per 100,000 population per year) of cancers, adjusted to 2000 US standard population age groups (under age 1, 1-4, 5-9, ..., 80-84, 85 and older). This indicator is relevant because cancer is a leading cause of death and it is important to identify cancers separately to better target interventions.

Cancer Risk

About Cancer Risk

Reducing the nation's cancer burden requires reducing the prevalence of behavioral and environmental factors that increase cancer risk.

- All cancers caused by cigarette smoking could be prevented. At least one-third of cancer deaths that occur in the United States are due to cigarette smoking.
- According to the American Cancer Society, about one-third of cancer deaths that occur in the United States each year are due to nutrition and physical activity factors, including obesity.
- National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention

Cancer Screenings

The American Cancer Society recommends that both men and women get a cancer-related checkup during a regular doctor's checkup. It should include examination for cancers of the thyroid, testicles, ovaries, lymph nodes, oral cavity, and skin, as well as health counseling about tobacco, sun exposure, diet and nutrition, risk factors, sexual practices, and environmental and occupational exposures.

Screening levels in the community were measured in the PRC Community Health Survey relative to: female breast cancer (mammography); cervical cancer (Pap smear testing); and colorectal cancer (sigmoidoscopy and fecal occult blood testing).

Female Breast Cancer Screening

About Screening for Breast Cancer

The US Preventive Services Task Force (USPSTF) recommends screening mammography, with or without clinical breast examination (CBE), every 1-2 years for women age 40 and older.

Rationale: The USPSTF found fair evidence that mammography screening every 12-33 months significantly reduces mortality from breast cancer. Evidence is strongest for women age 50-69, the age group generally included in screening trials. For women age 40-49, the evidence that screening mammography reduces mortality from breast cancer is weaker, and the absolute benefit of mammography is smaller, than it is for older women. Most, but not all, studies indicate a mortality benefit for women undergoing mammography at ages 40-49, but the delay in observed benefit in women younger than 50 makes it difficult to determine the incremental benefit of beginning screening at age 40 rather than at age 50.

The absolute benefit is smaller because the incidence of breast cancer is lower among women in their 40s than it is among older women. The USPSTF concluded that the evidence is also generalizable to women age 70 and older (who face a higher absolute risk for breast cancer) if their life expectancy is not compromised by comorbid disease. The absolute probability of benefits of regular mammography increase along a continuum with age, whereas the likelihood of harms from screening (false-positive results and unnecessary anxiety, biopsies, and cost) diminish from ages 40-70. The balance of benefits and potential harms, therefore, grows more favorable as women age. The precise age at which the potential benefits of mammography justify the possible harms is a subjective choice. The USPSTF did not find sufficient evidence to specify the optimal screening interval for women age 40-49.

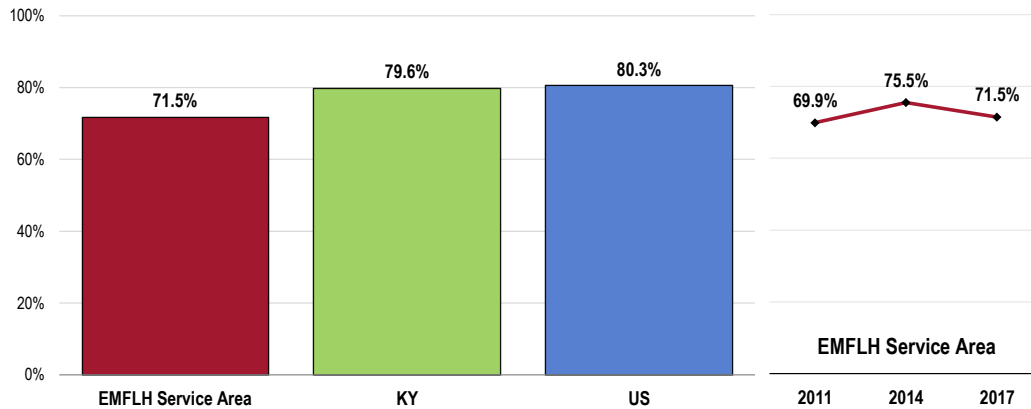
- US Preventive Services Task Force, Agency for Healthcare Research and Quality, US Department of Health & Human Services

Note that other organizations (e.g., American Cancer Society, American Academy of Family Physicians, American College of Physicians, National Cancer Institute) may have slightly different screening guidelines.

Breast Cancer Screening: “A mammogram is an x-ray of each breast to look for cancer. How long has it been since you had your last mammogram?” (Among women age 50-74 indicating screening in the past 2 years.)

Have Had a Mammogram in the Past Two Years (Among Women Age 50-74)

Healthy People 2020 Target = 81.1% or Higher



- Sources:
- 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 151]
 - Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2015 KY data.
 - 2015 PRC National Health Survey, Professional Research Consultants, Inc.
 - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective C-17]
- Notes:
- Reflects female respondents 50-74.

Cervical Cancer Screenings

About Screening for Cervical Cancer

The US Preventive Services Task Force (USPSTF) strongly recommends screening for cervical cancer in women who have been sexually active and have a cervix.

Rationale: The USPSTF found good evidence from multiple observational studies that screening with cervical cytology (Pap smears) reduces incidence of and mortality from cervical cancer. Direct evidence to determine the optimal starting and stopping age and interval for screening is limited. Indirect evidence suggests most of the benefit can be obtained by beginning screening within 3 years of onset of sexual activity or age 21 (whichever comes first) and screening at least every 3 years. The USPSTF concludes that the benefits of screening substantially outweigh potential harms.

The USPSTF recommends against routinely screening women older than age 65 for cervical cancer if they have had adequate recent screening with normal Pap smears and are not otherwise at high risk for cervical cancer.

Rationale: The USPSTF found limited evidence to determine the benefits of continued screening in women older than 65. The yield of screening is low in previously screened women older than 65 due to the declining incidence of high-grade cervical lesions after middle age. There is fair evidence that screening women older than 65 is associated with an increased risk for potential harms, including false-positive results and invasive procedures. The USPSTF concludes that the potential harms of screening are likely to exceed benefits among older women who have had normal results previously and who are not otherwise at high risk for cervical cancer.

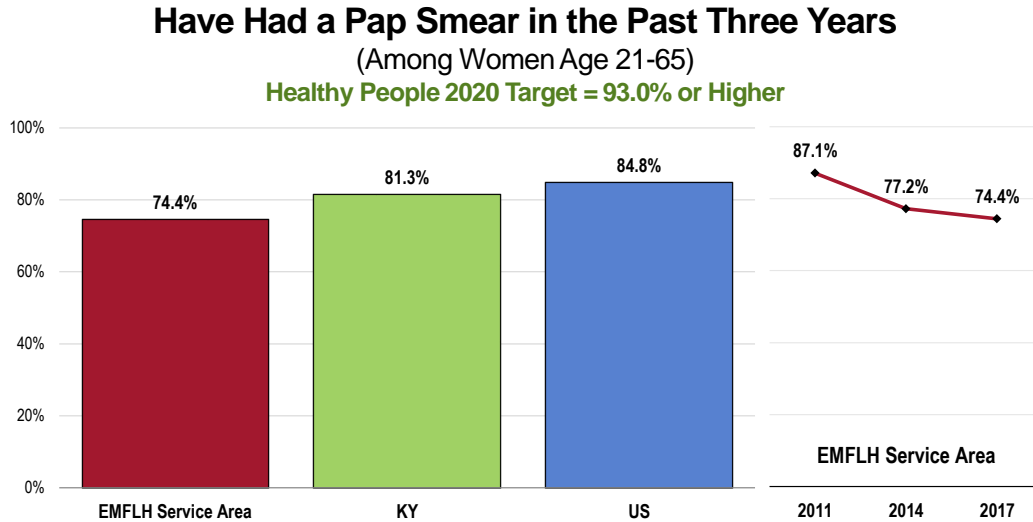
The USPSTF recommends against routine Pap smear screening in women who have had a total hysterectomy for benign disease.

Rationale: The USPSTF found fair evidence that the yield of cytologic screening is very low in women after hysterectomy and poor evidence that screening to detect vaginal cancer improves health outcomes. The USPSTF concludes that potential harms of continued screening after hysterectomy are likely to exceed benefits.

- US Preventive Services Task Force, Agency for Healthcare Research and Quality, US Department of Health & Human Services

Note that other organizations (e.g., American Cancer Society, American Academy of Family Physicians, American College of Physicians, National Cancer Institute) may have slightly different screening guidelines.

Cervical Cancer Screening: “A Pap test is a test for cancer of the cervix. How long has it been since you had your last Pap test?” (Calculated below among women age 21 to 65 indicating screening within the past 3 years.)



Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 152]
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2015 KY data.
 • 2015 PRC National Health Survey, Professional Research Consultants, Inc.
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective C-15]

Notes: • Reflects female respondents age 21 to 65.

Colorectal Cancer Screenings

About Screening for Colorectal Cancer

The USPSTF recommends screening for colorectal cancer using fecal occult blood testing, sigmoidoscopy, or colonoscopy in adults, beginning at age 50 years and continuing until age 75 years.

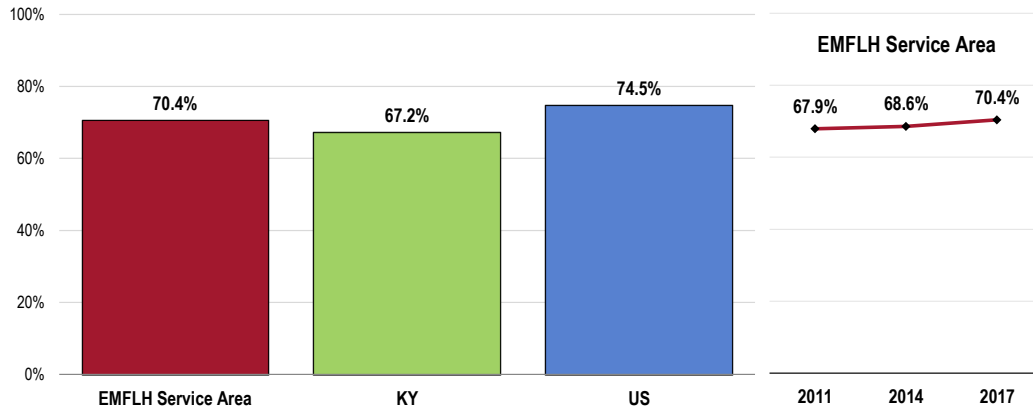
The evidence is convincing that screening for colorectal cancer with fecal occult blood testing, sigmoidoscopy, or colonoscopy detects early-stage cancer and adenomatous polyps. There is convincing evidence that screening with any of the three recommended tests (FOBT, sigmoidoscopy, colonoscopy) reduces colorectal cancer mortality in adults age 50 to 75 years. Follow-up of positive screening test results requires colonoscopy regardless of the screening test used.

- US Preventive Services Task Force, Agency for Healthcare Research and Quality, US Department of Health & Human Services

Note that other organizations (e.g., American Cancer Society, American Academy of Family Physicians, American College of Physicians, National Cancer Institute) may have slightly different screening guidelines.

Colorectal Cancer Screening: “Sigmoidoscopy and colonoscopy are exams in which a tube is inserted in the rectum to view the colon for signs of cancer or other health problems. How long has it been since your last sigmoidoscopy or colonoscopy?” and “A blood stool test is a test that may use a special kit at home to determine whether the stool contains blood. How long has it been since you had your last blood stool test?” (Calculated below among both genders age 50 to 75 indicating fecal occult blood testing within the past year and/or sigmoidoscopy/colonoscopy [lower endoscopy] within the past 10 years.)

Have Had a Colorectal Cancer Screening (Among Adults Age 50-75) Healthy People 2020 Target = 70.5% or Higher



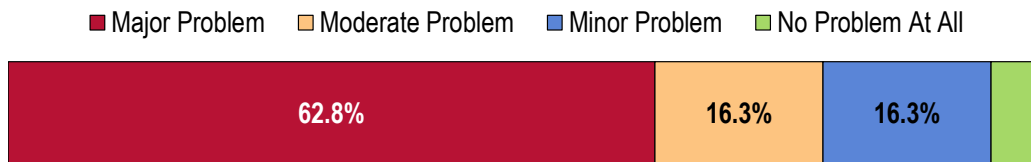
Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 155]
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2015 KY data.
 • 2015 PRC National Health Survey, Professional Research Consultants, Inc.
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective C-16]

Notes: • Asked of all respondents age 50 through 75.
 • In this case, the term "colorectal screening" refers to adults age 50-75 receiving a FOBT (fecal occult blood test) in the past year and/or a lower endoscopy (sigmoidoscopy/colonoscopy) in the past 10 years.

Key Informant Input: Cancer

The following chart outlines key informants' perceptions of the severity of *Cancer* as a problem in the community:

Perceptions of Cancer as a Problem in the Community (Key Informants, 2017)



Sources: • PRC Online Key Informant Survey, Professional Research Consultants, Inc.
 Notes: • Asked of all respondents.

Top Concerns

Among those rating this issue as a "major problem," reasons related to the following:

Prevalence/Incidence

Cancer cuts across all social, economic and political lines. Everyone in the community has been affected by it at some point. It still has a frightening stigma associated with it, even though there has been quite a bit of progress made in treatment. I recently had a funeral for someone who had cancer, and I'm planning the funeral for a member of the church who just died. The church is providing care for another member who has cancer. It is just an ever-present problem. – Community Leader

Seems more and more cancer-related deaths and illness in the community. – Community Leader

I would be interested to know our cancer diagnosis rate per capita. I would expect for this area that it would be high. We are fortunate to have treatment centers now available in Danville. Still, many are having issues with insurance coverage before necessary tests can be done in order to diagnose and treat cancer. – Community Leader

I know several people who have died from cancer, and I know several people that are currently being treated for cancer. – Community Leader

It touches so many folks. Lots of folks do not realize many forms of cancer are treatable if detected early. – Community Leader

I work in an office of 7 people, and 4 have had cancer. – Community Leader

There is a perception that there is an extremely high rate of cancer in our community, and most every family has been impacted by someone going through cancer treatment or by the loss of a family member. – Community Leader

Maybe because I live in small community, but more and more citizens have been diagnosed with cancer in the past 10 years. Or maybe I'm paying more attention. – Community Leader

Too many people with it here over time. Does it come from the water in Herrington, or the lead buried everywhere? - Community Leader

It appears in every family in one way or another. Advances have been made, but much more needs to be done. – Community Leader

Personally knowing people that have this terrible disease. – Community Leader

Looking at the data for the county. – Public Health Representative

Tobacco Use

The rate of smoking, obesity, and other factors contributing to cancer is highly prevalent in this community. – Community Leader

Cancer is everywhere. A lot is because of smoking. – Community Leader

Genetics and tobacco use. – Community Leader

High smoking rate and poor healthcare screening of our population. – Physician

Tobacco use. – Community Leader

Diagnosis/Treatment

Many cases with what seems to be antiquated methods of treatment. Does not seem to be slowing down. – Social Services Provider

Leading Cause of Death

According to the Lincoln Community Assessment for Year 2014, cancer was the leading cause of death. This data was also referenced in the 2015 Lincoln County Health Department Community Assessment Report. – Public Health Representative

Prevention

Despite its deadliness, people still refuse preventative measures. – Community Leader

Respiratory Disease

About Asthma & COPD

Asthma and chronic obstructive pulmonary disease (COPD) are significant public health burdens. Specific methods of detection, intervention, and treatment exist that may reduce this burden and promote health.

Asthma is a chronic inflammatory disorder of the airways characterized by episodes of reversible breathing problems due to airway narrowing and obstruction. These episodes can range in severity from mild to life threatening. Symptoms of asthma include wheezing, coughing, chest tightness, and shortness of breath. Daily preventive treatment can prevent symptoms and attacks and enable individuals who have asthma to lead active lives.

COPD is a preventable and treatable disease characterized by airflow limitation that is not fully reversible. The airflow limitation is usually progressive and associated with an abnormal inflammatory response of the lung to noxious particles or gases (typically from exposure to cigarette smoke). Treatment can lessen symptoms and improve quality of life for those with COPD.

The burden of respiratory diseases affects individuals and their families, schools, workplaces, neighborhoods, cities, and states. Because of the cost to the healthcare system, the burden of respiratory diseases also falls on society; it is paid for with higher health insurance rates, lost productivity, and tax dollars. Annual healthcare expenditures for asthma alone are estimated at \$20.7 billion.

Asthma. The prevalence of asthma has increased since 1980. However, deaths from asthma have decreased since the mid-1990s. The causes of asthma are an active area of research and involve both genetic and environmental factors.

Risk factors for asthma currently being investigated include:

- Having a parent with asthma
- Sensitization to irritants and allergens
- Respiratory infections in childhood
- Overweight

Asthma affects people of every race, sex, and age. However, significant disparities in asthma morbidity and mortality exist, in particular for low-income and minority populations. Populations with higher rates of asthma include: children; women (among adults) and boys (among children); African Americans; Puerto Ricans; people living in the Northeast United States; people living below the Federal poverty level; and employees with certain exposures in the workplace.

While there is not a cure for asthma yet, there are diagnoses and treatment guidelines that are aimed at ensuring that all people with asthma live full and active lives.

- Healthy People 2020 (www.healthypeople.gov)

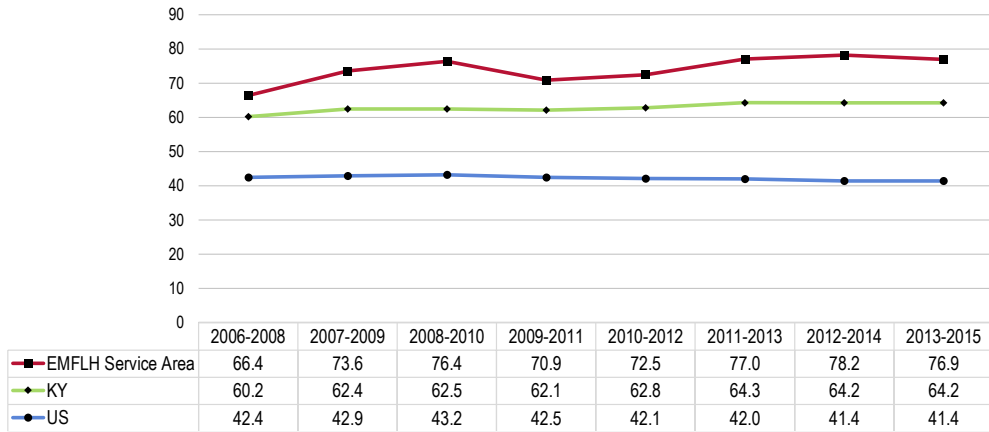
[NOTE: COPD was changed to chronic lower respiratory disease (CLRD) with the introduction of ICD-10 codes. CLRD is used in vital statistics reporting, but COPD is still widely used and commonly found in surveillance reports.]

Age-Adjusted Respiratory Disease Deaths

Chronic lower respiratory diseases (CLRD) are diseases affecting the lungs; the most deadly of these is chronic obstructive pulmonary disease (COPD), which includes emphysema and chronic bronchitis.

Pneumonia and influenza mortality is also illustrated in the following chart. For prevalence of vaccinations against pneumonia and influenza, see also *Immunization & Infectious Disease*.

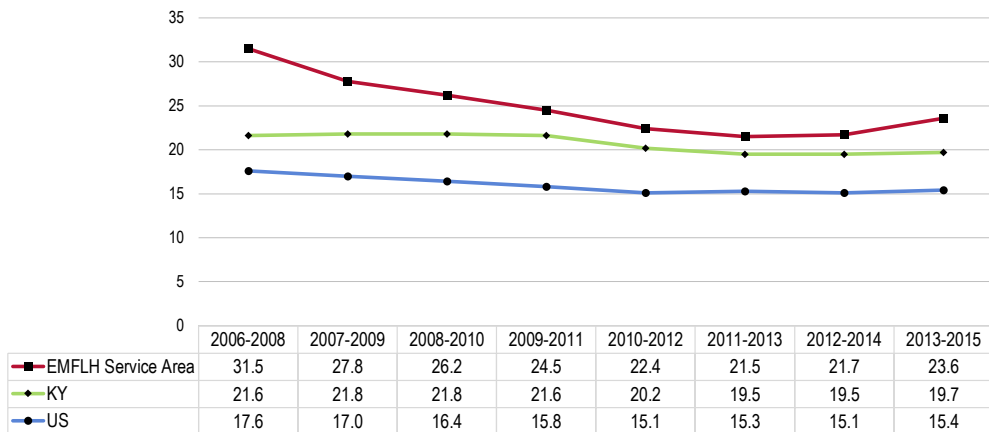
CLRD: Age-Adjusted Mortality Trends (Annual Average Deaths per 100,000 Population)



Sources: CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted March 2017.

Notes: Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10). Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population. CLRD is chronic lower respiratory disease.

Pneumonia/Influenza: Age-Adjusted Mortality Trends (Annual Average Deaths per 100,000 Population)



Sources: CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted March 2017.

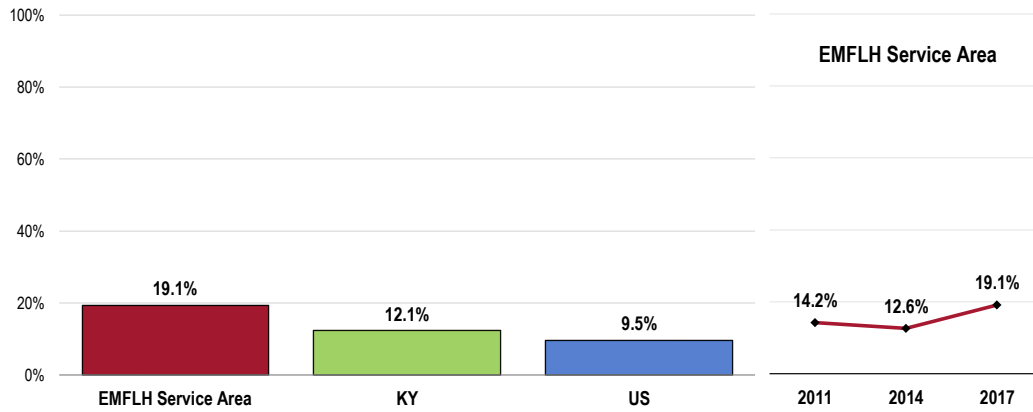
Notes: Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10). Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Prevalence of Respiratory Diseases

COPD

“Would you please tell me if you have ever suffered from or been diagnosed with COPD or chronic obstructive pulmonary disease, including bronchitis or emphysema?”

Prevalence of Chronic Obstructive Pulmonary Disease (COPD)



Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 24]
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2015 KY data.
 • 2015 PRC National Health Survey, Professional Research Consultants, Inc.

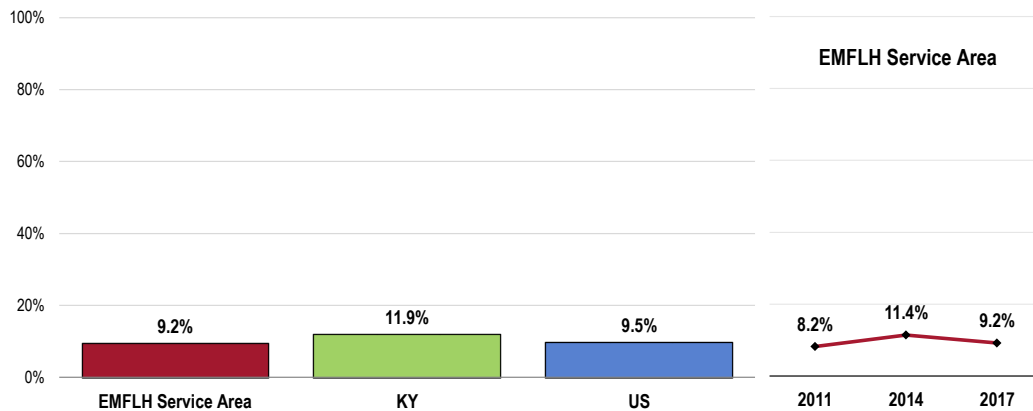
Notes: • Asked of all respondents.
 • Includes those having ever suffered from or been diagnosed with COPD or chronic obstructive pulmonary disease, including bronchitis or emphysema.
 • In prior data, the term "chronic lung disease" was used, which also included bronchitis or emphysema.

Asthma

Adults: "Have you ever been told by a doctor, nurse, or other health professional that you had asthma?" and "Do you still have asthma?" (Calculated below as a prevalence of all adults who have ever been diagnosed with asthma and who still have asthma ["current asthma"]).

Children: "Has a doctor or other health professional ever told you that this child had asthma?" and "Does this child still have asthma?" (Calculated here as a prevalence of all children who have ever been diagnosed with asthma and who still have asthma ["current asthma"]).

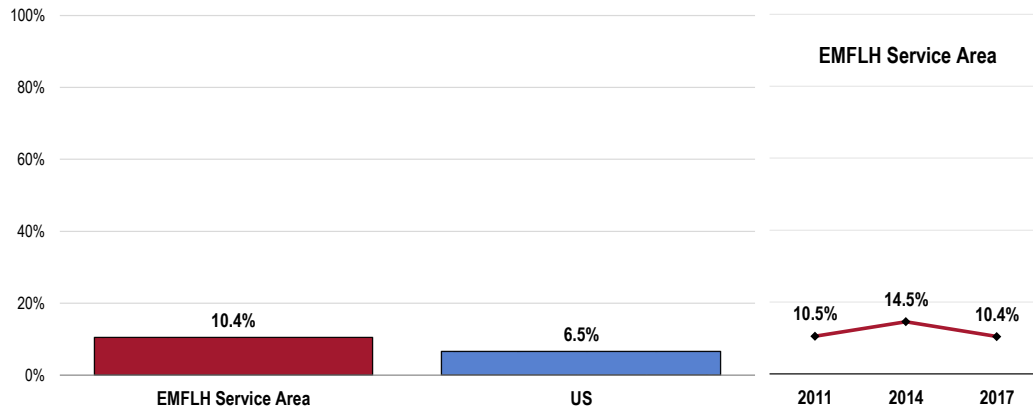
Adult Asthma: Current Prevalence



Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 156]
 • 2015 PRC National Health Survey, Professional Research Consultants, Inc.
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2015 KY data.

Notes: • Asked of all respondents.
 • Includes those who have ever been diagnosed with asthma, and who report that they still have asthma.

Childhood Asthma: Current Prevalence (Among Parents of Children Age 0-17)

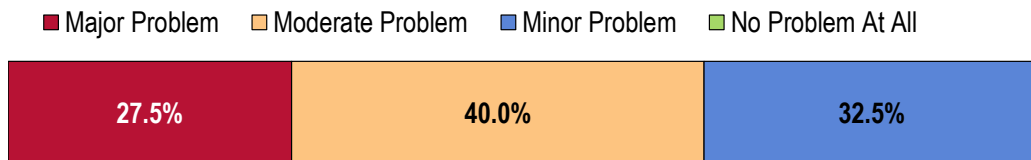


Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 157]
 • 2015 PRC National Health Survey, Professional Research Consultants, Inc.
 Notes: • Asked of all respondents with children 0 to 17 in the household.
 • Includes children who have ever been diagnosed with asthma, and whom are reported to still have asthma.

Key Informant Input: Respiratory Disease

The following chart outlines key informants' perceptions of the severity of *Respiratory Disease* as a problem in the community:

Perceptions of Respiratory Diseases as a Problem in the Community (Key Informants, 2017)



Sources: • PRC Online Key Informant Survey, Professional Research Consultants, Inc.
 Notes: • Asked of all respondents.

Top Concerns

Among those rating this issue as a “major problem,” reasons related to the following:

Tobacco Use

- High smoking rate and one of the worst areas in the country for allergens. – Physician
- Smoking and secondhand smoke. – Community Leader
- Tobacco use. – Community Leader
- Too much smoking. – Community Leader
- High smoking rate. – Community Leader

Prevalence/Incidence

- COPD is prevalent in our clients and staff. – Social Services Provider
- I see a lot of people with COPD. – Community Leader

Injury & Violence

About Injury & Violence

Injuries and violence are widespread in society. Both unintentional injuries and those caused by acts of violence are among the top 15 killers for Americans of all ages. Many people accept them as “accidents,” “acts of fate,” or as “part of life.” However, most events resulting in injury, disability, or death are predictable and preventable.

Injuries are the leading cause of death for Americans ages 1 to 44, and a leading cause of disability for all ages, regardless of sex, race/ethnicity, or socioeconomic status. More than 180,000 people die from injuries each year, and approximately 1 in 10 sustains a nonfatal injury serious enough to be treated in a hospital emergency department.

Beyond their immediate health consequences, injuries and violence have a significant impact on the well-being of Americans by contributing to:

- Premature death
- Disability
- Poor mental health
- High medical costs
- Lost productivity

The effects of injuries and violence extend beyond the injured person or victim of violence to family members, friends, coworkers, employers, and communities.

Numerous factors can affect the risk of unintentional injury and violence, including individual behaviors, physical environment, access to health services (ranging from pre-hospital and acute care to rehabilitation), and social environment (from parental monitoring and supervision of youth to peer group associations, neighborhoods, and communities).

Interventions addressing these social and physical factors have the potential to prevent unintentional injuries and violence. Efforts to prevent unintentional injury may focus on:

- Modifications of the environment
- Improvements in product safety
- Legislation and enforcement
- Education and behavior change
- Technology and engineering

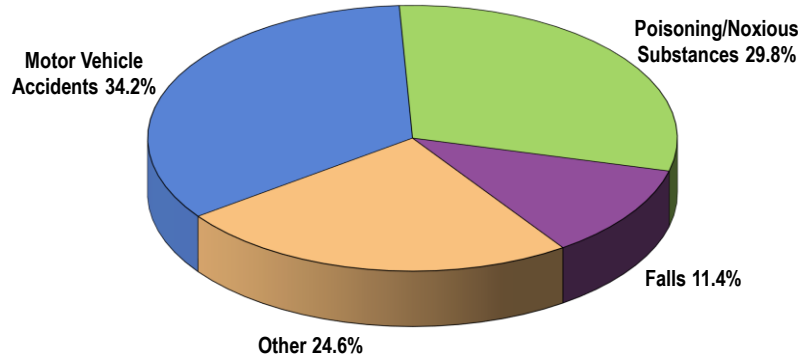
Efforts to prevent violence may focus on:

- Changing social norms about the acceptability of violence
- Improving problem-solving skills (for example, parenting, conflict resolution, coping)
- Changing policies to address the social and economic conditions that often give rise to violence
- Healthy People 2020 (www.healthypeople.gov)

Leading Causes of Accidental Death

Leading causes of accidental death in the area include the following:

Leading Causes of Accidental Death (EMFLH Service Area, 2013-2015)



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted March 2017.
 Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).

Unintentional Injury

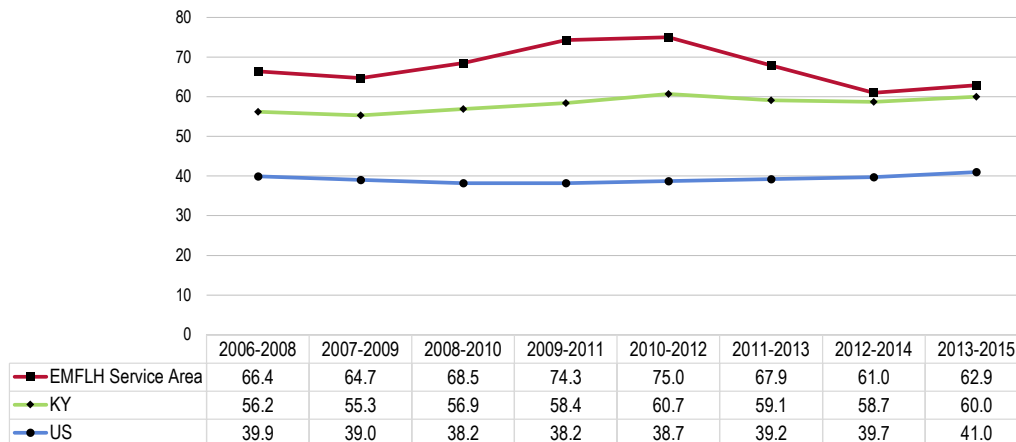
Age-Adjusted Unintentional Injury Deaths

The following chart outlines age-adjusted mortality rates for unintentional injury in the area.

Unintentional Injuries: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)

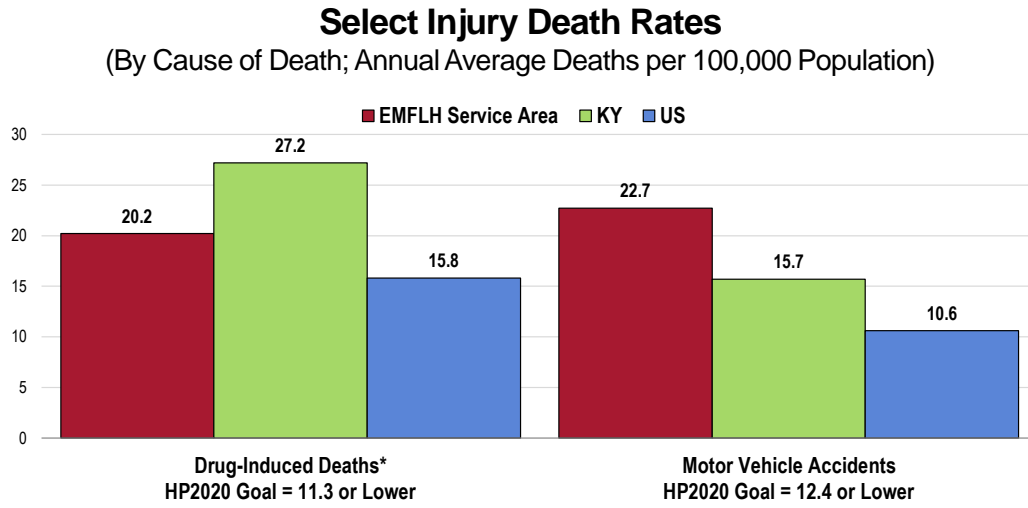
Healthy People 2020 Target = 36.4 or Lower



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted March 2017.
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective IVP-11]
 Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
 • Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Age-Adjusted Deaths for Selected Injury-Related Causes

This chart shows age-adjusted mortality rates for drug-induced deaths and motor vehicle crash deaths.



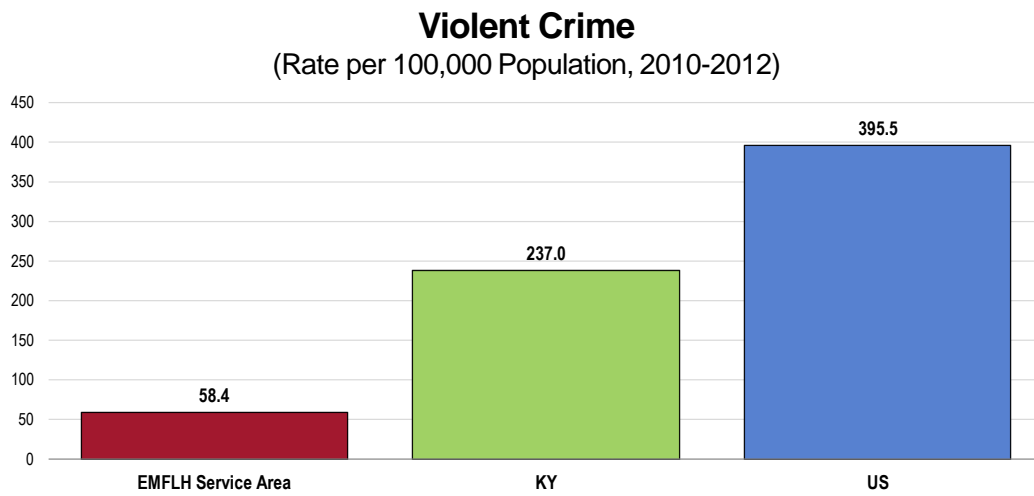
Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted March 2017.
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective IVP-13.1, IVP-23.2, SA-12]

Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
 • Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.
 • *Drug-induced deaths include both intentional and unintentional drug overdoses.

Intentional Injury (Violence)

Violent Crime

Violent crime is composed of four offenses (FBI Index offenses): murder and non-negligent manslaughter; forcible rape; robbery; and aggravated assault. Note that the quality of crime data can vary widely from location to location, depending on the consistency and completeness of reporting among various jurisdictions.

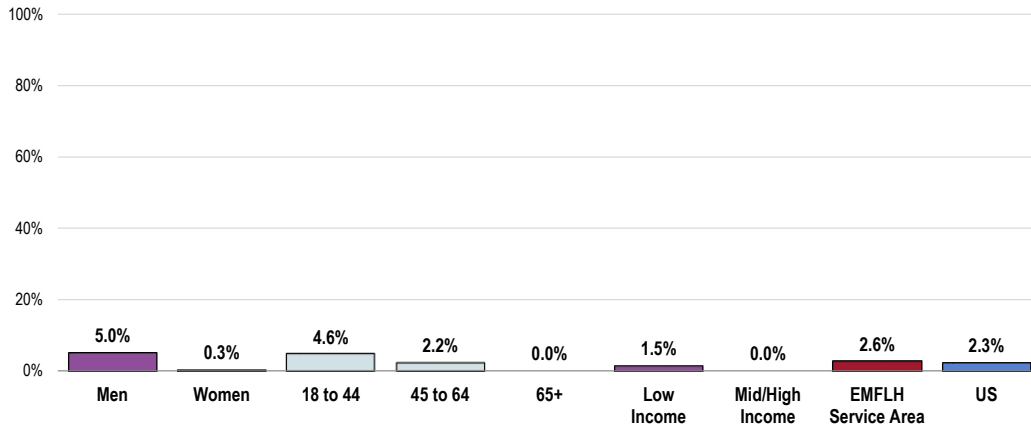


Sources: • Federal Bureau of Investigation, FBI Uniform Crime Reports.
 • Retrieved March 2017 from Community Commons at <http://www.chna.org>.

Notes: • This indicator reports the rate of violent crime offenses reported by the sheriff's office or county police department per 100,000 residents. Violent crime includes homicide, rape, robbery, and aggravated assault. This indicator is relevant because it assesses community safety.
 • Participation by law enforcement agencies in the UCR program is voluntary. Sub-state data do not necessarily represent an exhaustive list of crimes due to gaps in reporting. Also, some institutions of higher education have their own police departments, which handle offenses occurring within campus grounds; these offenses are not included in the violent crime statistics, but can be obtained from the Uniform Crime Reports Universities and Colleges data tables.

Violent Crime Experience: “Have you been the victim of a violent crime in your area in the past 5 years?”

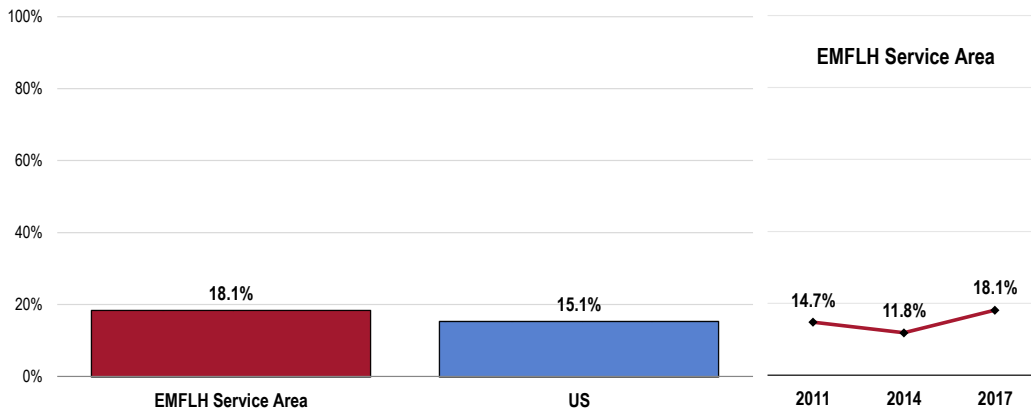
Victim of a Violent Crime in the Past Five Years (EMFLH Service Area, 2017)



Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 49]
 Notes: • Asked of all respondents.
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Intimate Partner Violence: “The next questions are about different types of violence in relationships with an intimate partner. By an intimate partner, I mean any current or former spouse, boyfriend, or girlfriend. Someone you were dating, or romantically or sexually intimate with, would also be considered an intimate partner. Has an intimate partner ever hit, slapped, pushed, kicked, or hurt you in any way?”

Have Ever Been Hit, Slapped, Pushed, Kicked, or Hurt in Any Way by an Intimate Partner



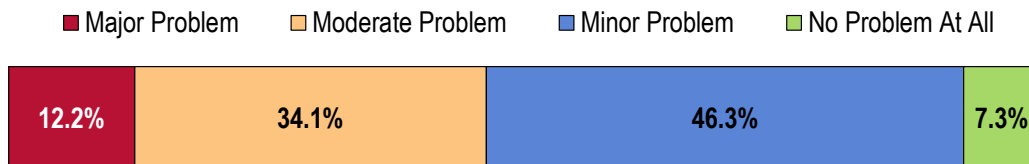
Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 50]
 • 2015 PRC National Health Survey, Professional Research Consultants, Inc.
 Notes: • Asked of all respondents.

Key Informant Input: Injury & Violence

The following chart outlines key informants' perceptions of the severity of *Injury & Violence* as a problem in the community:

Perceptions of Injury and Violence as a Problem in the Community

(Key Informants, 2017)



Sources: • PRC Online Key Informant Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.

Top Concerns

Among those rating this issue as a “major problem,” reasons related to the following:

Alcohol/Drug Use

Too much drug abuse, which leads to behavior that results in injury and violence. Remember, alcohol is a drug. – Community Leader

Increase in violent crimes due to substance abuse. – Social Services Provider

I think it relates to drug use. – Community Leader

Diabetes

About Diabetes

Diabetes mellitus occurs when the body cannot produce or respond appropriately to insulin. Insulin is a hormone that the body needs to absorb and use glucose (sugar) as fuel for the body's cells. Without a properly functioning insulin signaling system, blood glucose levels become elevated and other metabolic abnormalities occur, leading to the development of serious, disabling complications. Many forms of diabetes exist; the three common types are Type 1, Type 2, and gestational diabetes. Effective therapy can prevent or delay diabetic complications.

Diabetes mellitus:

- Lowers life expectancy by up to 15 years.
- Increases the risk of heart disease by 2 to 4 times.
- Is the leading cause of kidney failure, lower limb amputations, and adult-onset blindness.

The rate of diabetes mellitus continues to increase both in the United States and throughout the world. Due to the steady rise in the number of persons with diabetes mellitus, and possibly earlier onset of type 2 diabetes mellitus, there is growing concern about the possibility that the increase in the number of persons with diabetes mellitus and the complexity of their care might overwhelm existing healthcare systems.

People from minority populations are more frequently affected by type 2 diabetes. Minority groups constitute 25% of all adult patients with diabetes in the US and represent the majority of children and adolescents with type 2 diabetes.

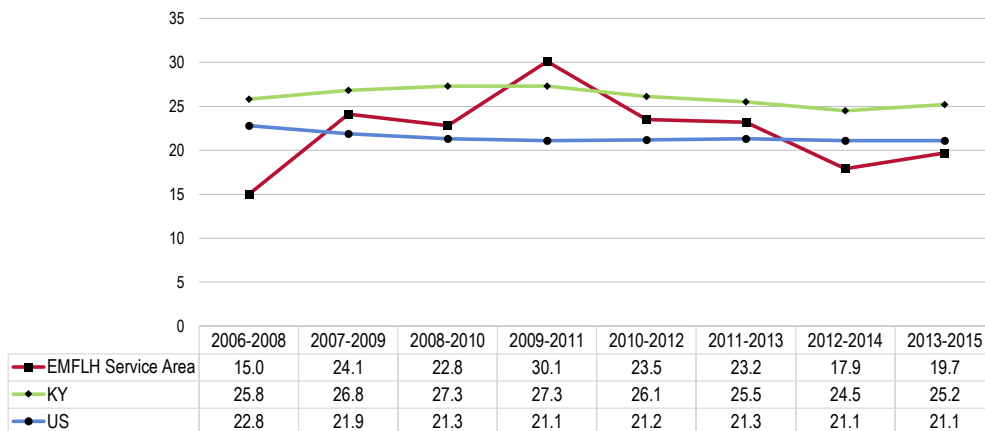
Lifestyle change has been proven effective in preventing or delaying the onset of type 2 diabetes in high-risk individuals.

- Healthy People 2020 (www.healthypeople.gov)

Age-Adjusted Diabetes Deaths

Age-adjusted diabetes mortality for the area is shown in the following chart.

Diabetes: Age-Adjusted Mortality Trends
(Annual Average Deaths per 100,000 Population)
Healthy People 2020 Target = 20.5 or Lower (Adjusted)



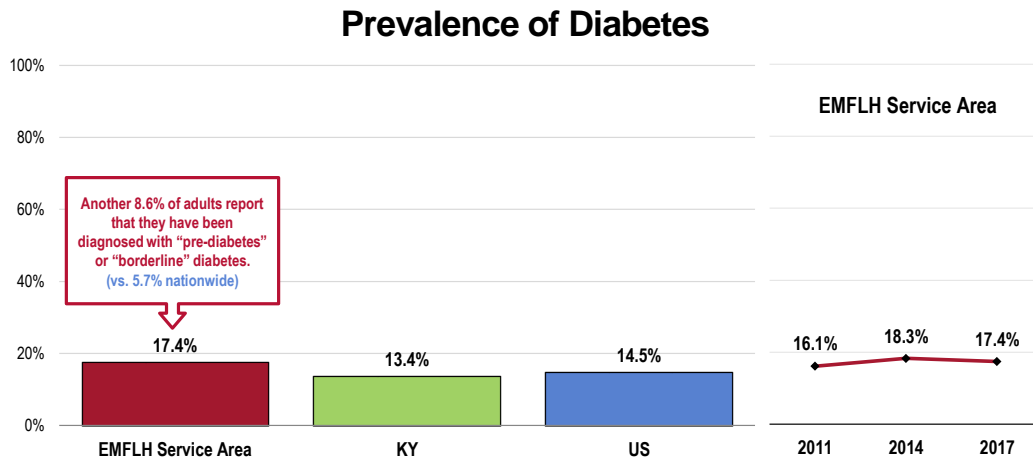
Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted March 2017.

Notes: • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective D-3]
• Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
• Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.
• The Healthy People 2020 target for Diabetes is adjusted to account for only diabetes mellitus coded deaths.

Prevalence of Diabetes

“Have you ever been told by a doctor that you have diabetes? (If female, add: not counting diabetes only occurring during pregnancy?)”

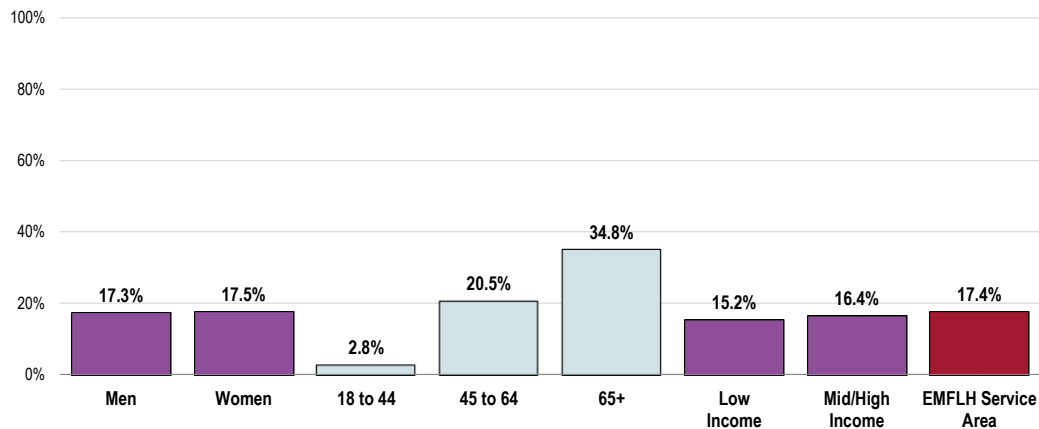
“Have you ever been told by a doctor or other health professional that you have pre-diabetes or borderline diabetes? (If female, add: other than during pregnancy?)”



Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 158]
 • 2015 PRC National Health Survey, Professional Research Consultants, Inc.
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2015 KY data.

Notes: • Asked of all respondents.

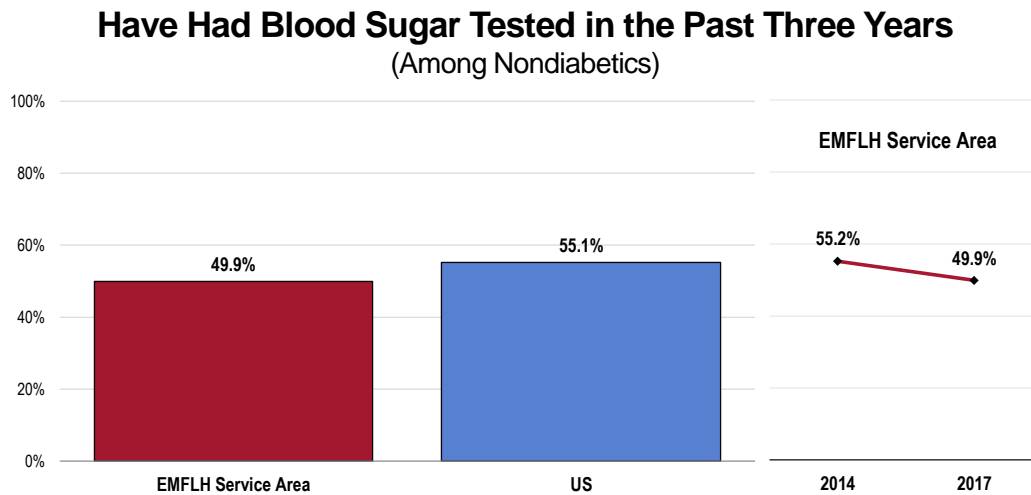
Prevalence of Diabetes (EMFLH Service Area, 2017)



Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 158]
 Notes: • Asked of all respondents.
 • Income categories reflect respondent’s household income as a ratio to the federal poverty level (FPL) for their household size. “Low Income” includes households with incomes up to 200% of the federal poverty level; “Mid/High Income” includes households with incomes at 200% or more of the federal poverty level.
 • Excludes gestational diabetes (occurring only during pregnancy).

Diabetes Testing

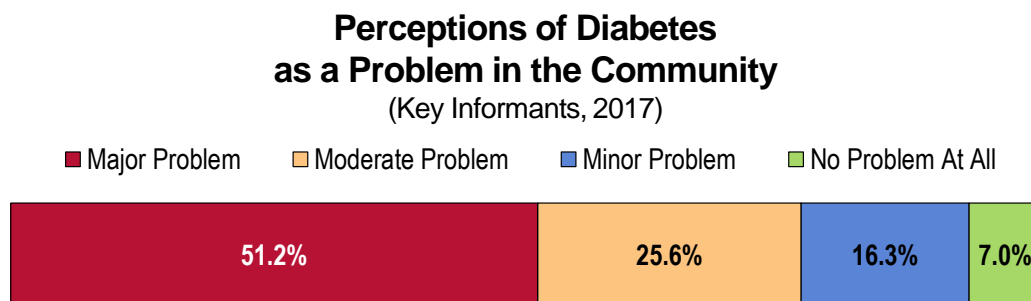
Adults who do not have diabetes: “Have you had a test for high blood sugar or diabetes within the past three years?”



Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 39]
 • 2015 PRC National Health Survey, Professional Research Consultants, Inc.
 Notes: • Asked of respondents who have not been diagnosed with diabetes.

Key Informant Input: Diabetes

The following chart outlines key informants' perceptions of the severity of *Diabetes* as a problem in the community:



Sources: • PRC Online Key Informant Survey, Professional Research Consultants, Inc.
 Notes: • Asked of all respondents.

Challenges

Among those rating diabetes as a “major problem,” the biggest challenges for people with diabetes are seen as:

Lifestyle

- Sugary drinks. – Community Leader*
- Diet and exercise. – Community Leader*
- Personal care and nutrition. – Social Services Provider*
- Behavioral changes. – Public Health Representative*
- Eating out. – Community Leader*
- Diet control. – Community Leader*

Obesity

- Kentucky in general has a problem with obesity, which has caused a high rate of diabetes. Diet is probably the biggest problem. – Community Leader*
- Overweight, poor diet. – Community Leader*
- Obesity. – Community Leader*

Diagnosis/Treatment

- Identifying and slowing down its progression. – Community Leader*
- Tight control of existing disease and poor prevention of developing it. – Physician*

Health Education

- They are largely uneducated as to how to prevent diabetes and unwilling to accept that for many with diabetes, it is lifestyle-related. – Community Leader*
- Services available, but people do not take advantage of those services. – Public Health Representative*

Insufficient Physical Activity

- Lack of exercise. Our community is a walk-friendly community. We have a great walking track at the park, and I wish more would utilize it. – Community Leader*

Lack of Specialists

- No endocrinologist, and the bulk of nurse practitioners are not well-trained in DM management. – Physician*

Prevalence/Incidence

- Large numbers. – Social Services Provider*

Socioeconomic Factors

- Low income and lack of education about diet. – Community Leader*

Alzheimer’s Disease

About Dementia

Dementia is the loss of cognitive functioning—thinking, remembering, and reasoning—to such an extent that it interferes with a person’s daily life. Dementia is not a disease itself, but rather a set of symptoms. Memory loss is a common symptom of dementia, although memory loss by itself does not mean a person has dementia. Alzheimer’s disease is the most common cause of dementia, accounting for the majority of all diagnosed cases.

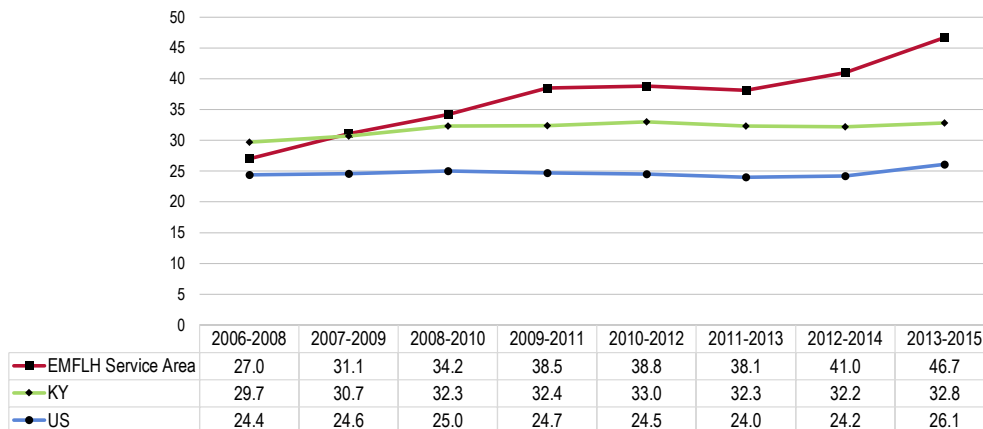
Alzheimer’s disease is the 6th leading cause of death among adults age 18 years and older. Estimates vary, but experts suggest that up to 5.1 million Americans age 65 years and older have Alzheimer’s disease. These numbers are predicted to more than double by 2050 unless more effective ways to treat and prevent Alzheimer’s disease are found.

- Healthy People 2020 (www.healthypeople.gov)

Age-Adjusted Alzheimer’s Disease Deaths

Age-adjusted Alzheimer’s disease mortality is outlined below.

Alzheimer's Disease: Age-Adjusted Mortality Trends
(Annual Average Deaths per 100,000 Population)



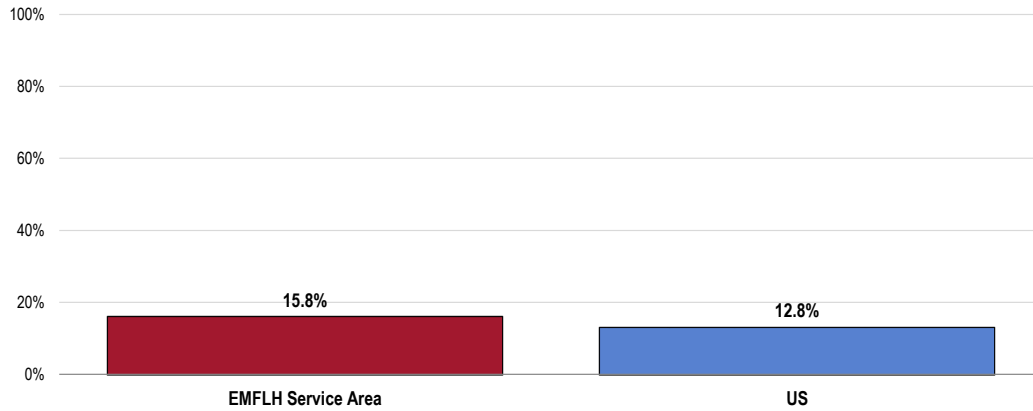
Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted March 2017.

Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
• Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Confusion & Memory Loss

Adults age 45 and older: “During the past 12 months, have you experienced confusion or memory loss that is happening more often or getting worse?”

Experienced Increasing Confusion/Memory Loss in Past Year (Among Respondents Age 45 and Older)

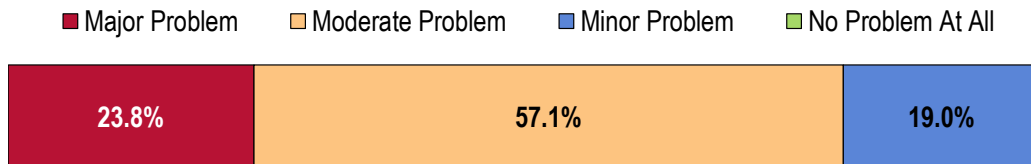


Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 127]
 • 2015 PRC National Health Survey, Professional Research Consultants, Inc.
 Notes: • Asked of those respondents age 45 and older.

Key Informant Input: Dementias, Including Alzheimer’s Disease

The following chart outlines key informants’ perceptions of the severity of *Dementias, Including Alzheimer’s Disease* as a problem in the community:

Perceptions of Dementia/Alzheimer's Disease as a Problem in the Community (Key Informants, 2017)



Sources: • PRC Online Key Informant Survey, Professional Research Consultants, Inc.
 Notes: • Asked of all respondents.

Top Concerns

Among those rating this issue as a “major problem,” reasons related to the following:

Aging Population

- *People are living longer. As a result, there is an increased number of people that develop dementia. – Community Leader*
- *Our community is aging, and the facility for them is limited. – Community Leader*
- *Elderly population. – Community Leader*
- *Because people are living longer and having accidents. – Community Leader*

Prevalence/Incidence

- *Increasing numbers of dementia, with few equipped to treat or advise. – Physician*
- *Affects almost every family in some way. – Community Leader*

Access to Care/Services

- *It incapacitates folks and makes them totally dependent on resources that just may not be there. – Community Leader*

Kidney Disease

About Kidney Disease

Chronic kidney disease and end-stage renal disease are significant public health problems in the United States and a major source of suffering and poor quality of life for those afflicted. They are responsible for premature death and exact a high economic price from both the private and public sectors. Nearly 25% of the Medicare budget is used to treat people with chronic kidney disease and end-stage renal disease.

Genetic determinants have a large influence on the development and progression of chronic kidney disease. It is not possible to alter a person's biology and genetic determinants; however, environmental influences and individual behaviors also have a significant influence on the development and progression of chronic kidney disease. As a result, some populations are disproportionately affected. Successful behavior modification is expected to have a positive influence on the disease.

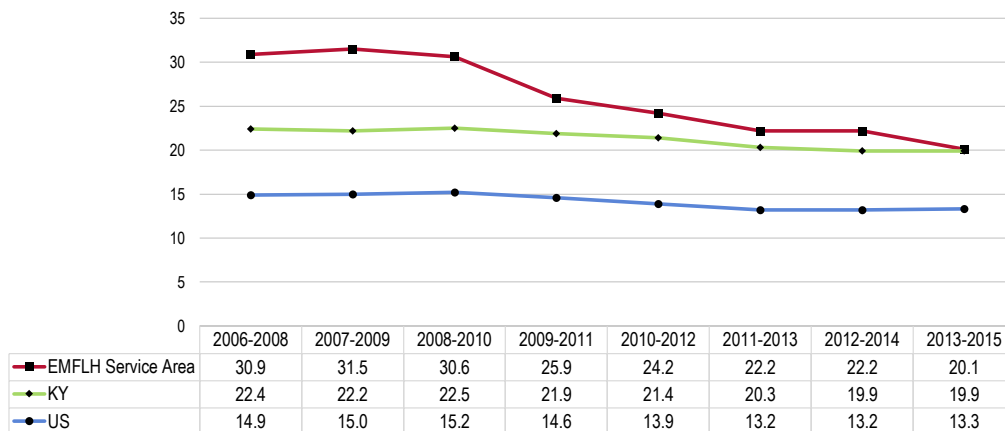
Diabetes is the most common cause of kidney failure. The results of the Diabetes Prevention Program (DPP) funded by the national Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) show that moderate exercise, a healthier diet, and weight reduction can prevent development of type 2 diabetes in persons at risk.

- Healthy People 2020 (www.healthypeople.gov)

Age-Adjusted Kidney Disease Deaths

Age-adjusted kidney disease mortality is described in the following chart.

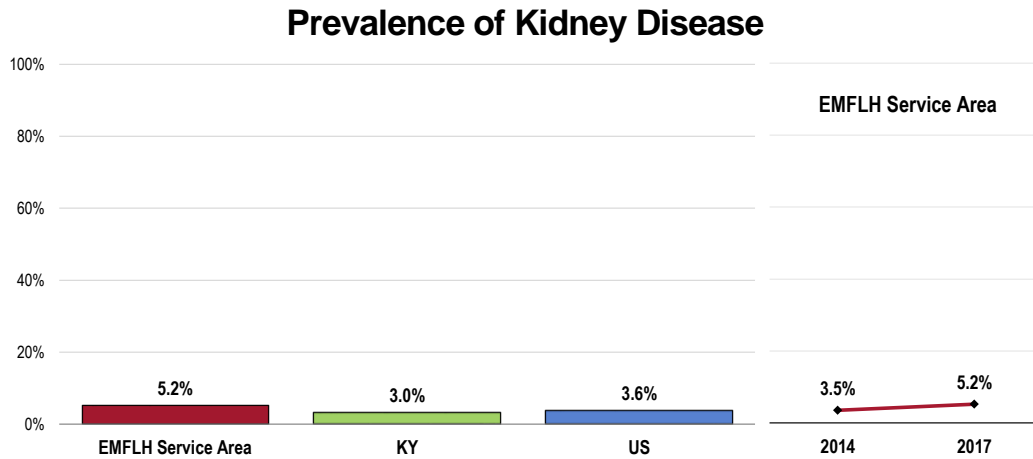
Kidney Disease: Age-Adjusted Mortality Trends
(Annual Average Deaths per 100,000 Population)



- Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted March 2017.
- Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
 - Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Prevalence of Kidney Disease

“Would you please tell me if you have ever suffered from or been diagnosed with kidney disease?”

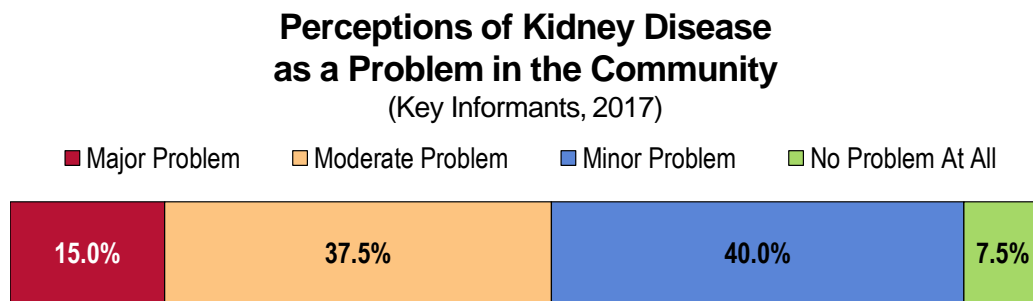


Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 32]
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2015 KY data.
 • 2015 PRC National Health Survey, Professional Research Consultants, Inc.

Notes: • Asked of all respondents.

Key Informant Input: Kidney Disease

The following chart outlines key informants’ perceptions of the severity of *Kidney Disease* as a problem in the community:



Sources: • PRC Online Key Informant Survey, Professional Research Consultants, Inc.
 Notes: • Asked of all respondents.

Top Concerns

Among those rating this issue as a “major problem,” reasons related to the following:

Aging Population

Elderly population. – Community Leader

Alcohol/Drug Use

Continued drug abuse. – Community Leader

Comorbidities

| *Obesity, high blood pressure, diabetes. – Physician*

Lack of Specialists

| *I don't know of a specialist in this area. – Community Leader*

Treatment

| *Medications that work through the kidneys. – Community Leader*

Potentially Disabling Conditions

About Arthritis, Osteoporosis & Chronic Back Conditions

There are more than 100 types of arthritis. Arthritis commonly occurs with other chronic conditions, such as diabetes, heart disease, and obesity. Interventions to treat the pain and reduce the functional limitations from arthritis are important, and may also enable people with these other chronic conditions to be more physically active. Arthritis affects 1 in 5 adults and continues to be the most common cause of disability. It costs more than \$128 billion per year. All of the human and economic costs are projected to increase over time as the population ages. There are interventions that can reduce arthritis pain and functional limitations, but they remain underused. These include: increased physical activity; self-management education; and weight loss among overweight/obese adults.

Osteoporosis is a disease marked by reduced bone strength leading to an increased risk of fractures (broken bones). In the United States, an estimated 5.3 million people age 50 years and older have osteoporosis. Most of these people are women, but about 0.8 million are men. Just over 34 million more people, including 12 million men, have low bone mass, which puts them at increased risk for developing osteoporosis. Half of all women and as many as 1 in 4 men age 50 years and older will have an osteoporosis-related fracture in their lifetime.

Chronic back pain is common, costly, and potentially disabling. About 80% of Americans experience low back pain in their lifetime. It is estimated that each year:

- 15%-20% of the population develop protracted back pain.
- 2-8% have chronic back pain (pain that lasts more than 3 months).
- 3-4% of the population is temporarily disabled due to back pain.
- 1% of the working-age population is disabled completely and permanently as a result of low back pain.

Americans spend at least \$50 billion each year on low back pain. Low back pain is the:

- 2nd leading cause of lost work time (after the common cold).
- 3rd most common reason to undergo a surgical procedure.
- 5th most frequent cause of hospitalization.

Arthritis, osteoporosis, and chronic back conditions all have major effects on quality of life, the ability to work, and basic activities of daily living.

- Healthy People 2020 (www.healthypeople.gov)

Arthritis, Osteoporosis, & Chronic Back Conditions

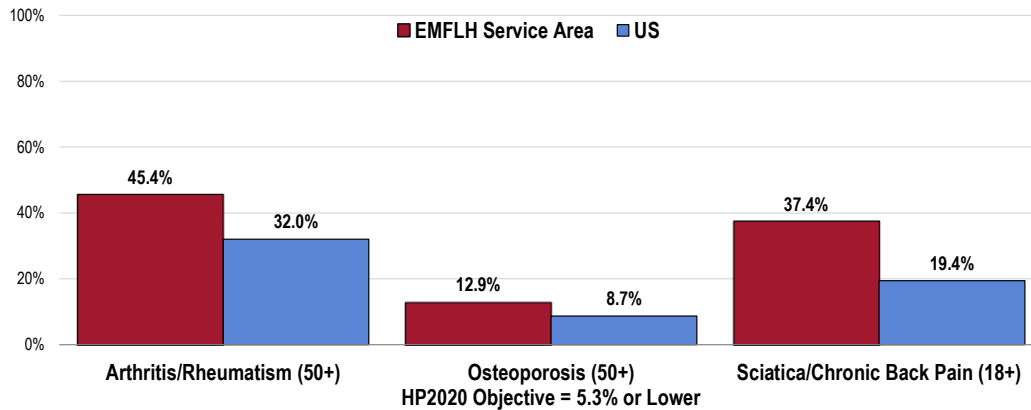
“Would you please tell me if you have ever suffered from or been diagnosed with arthritis or rheumatism?” (Reported here among only those age 50+.)

“Would you please tell me if you have ever suffered from or been diagnosed with osteoporosis?” (Reported here among only those age 50+.)

“Would you please tell me if you have ever suffered from or been diagnosed with sciatica or chronic back pain?” (Reported here among all adults age 18+.)

See also *Activity Limitations* in the **General Health Status** section of this report.

Prevalence of Potentially Disabling Conditions



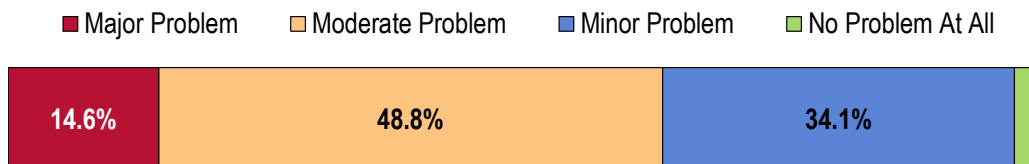
Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 28, 161-162]
 • 2015 PRC National Health Survey, Professional Research Consultants, Inc.
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective AOCBC-10]

Notes: • The sciatica indicator reflects the total sample of respondents; the arthritis and osteoporosis columns reflect adults age 50+.

Key Informant Input: Arthritis, Osteoporosis & Chronic Back Conditions

The following chart outlines key informants' perceptions of the severity of *Arthritis, Osteoporosis & Chronic Back Conditions* as a problem in the community:

Perceptions of Arthritis/Osteoporosis/Back Conditions as a Problem in the Community (Key Informants, 2017)



Sources: • PRC Online Key Informant Survey, Professional Research Consultants, Inc.
 Notes: • Asked of all respondents.

Top Concerns

Among those rating this issue as a "major problem," reasons related to the following:

Prevalence/Incidence

History of patients seeking services, self-report conditions. – Public Health Representative
Lots of people being treated by chiropractors. – Community Leader

Aging Population

An elderly community would have these problems. – Community Leader

Lifestyle

Poor nutrition and exercise with smoking contributes to osteoporosis, and obesity combined with poor exercise increases back problems and arthritis. – Physician

Vision & Hearing Impairment

Vision Trouble

About Vision

Vision is an essential part of everyday life, influencing how Americans of all ages learn, communicate, work, play, and interact with the world. Yet millions of Americans live with visual impairment, and many more remain at risk for eye disease and preventable eye injury.

The eyes are an important, but often overlooked, part of overall health. Despite the preventable nature of some vision impairments, many people do not receive recommended screenings and exams. A visit to an eye care professional for a comprehensive dilated eye exam can help to detect common vision problems and eye diseases, including diabetic retinopathy, glaucoma, cataract, and age-related macular degeneration.

These common vision problems often have no early warning signs. If a problem is detected, an eye care professional can prescribe corrective eyewear, medicine, or surgery to minimize vision loss and help a person see his or her best.

Healthy vision can help to ensure a healthy and active lifestyle well into a person's later years. Educating and engaging families, communities, and the nation is critical to ensuring that people have the information, resources, and tools needed for good eye health.

- Healthy People 2020 (www.healthypeople.gov)

Hearing Trouble

About Hearing & Other Sensory or Communication Disorders

An impaired ability to communicate with others or maintain good balance can lead many people to feel socially isolated, have unmet health needs, have limited success in school or on the job. Communication and other sensory processes contribute to our overall health and well-being. Protecting these processes is critical, particularly for people whose age, race, ethnicity, gender, occupation, genetic background, or health status places them at increased risk.

Many factors influence the numbers of Americans who are diagnosed and treated for hearing and other sensory or communication disorders, such as social determinants (social and economic standings, age of diagnosis, cost and stigma of wearing a hearing aid, and unhealthy lifestyle choices). In addition, biological causes of hearing loss and other sensory or communication disorders include: genetics; viral or bacterial infections; sensitivity to certain drugs or medications; injury; and aging.

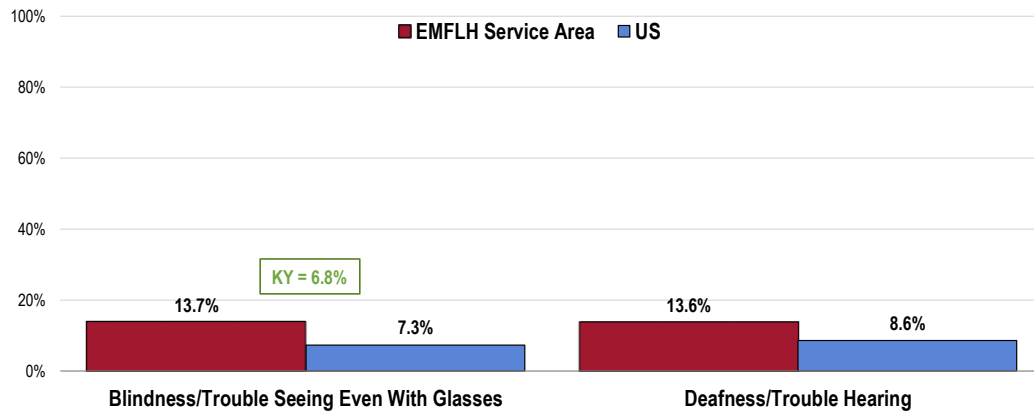
As the nation's population ages and survival rates for medically fragile infants and for people with severe injuries and acquired diseases improve, the prevalence of sensory and communication disorders is expected to rise.

- Healthy People 2020 (www.healthypeople.gov)

“Would you please tell me if you have ever suffered from or been diagnosed with blindness or trouble seeing, even when wearing glasses?”

“Would you please tell me if you have ever suffered from or been diagnosed with deafness or trouble hearing?”

Prevalence of Blindness/Deafness



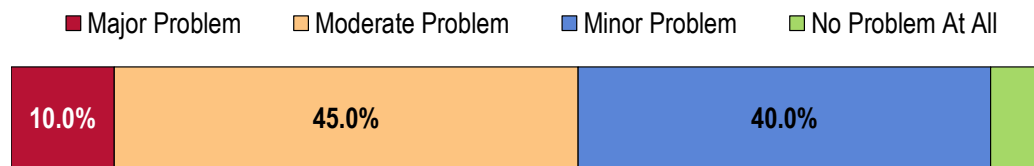
Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 25-26]
 • 2015 PRC National Health Survey, Professional Research Consultants, Inc.
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2015 KY data.

Notes: • Reflects the total sample of respondents.

Key Informant Input: Vision & Hearing

The following chart outlines key informants' perceptions of the severity of *Vision & Hearing* as a problem in the community:

Perceptions of Vision and Hearing as a Problem in the Community (Key Informants, 2017)



Sources: • PRC Online Key Informant Survey, Professional Research Consultants, Inc.
 Notes: • Asked of all respondents.

Top Concerns

Among those rating this issue as a “major problem,” reasons related to the following:

Prevalence/Incidence

History of patients seeking services, self-report conditions. – Public Health Representative
Lots of people being treated by chiropractors. – Community Leader

Lifestyle

Poor nutrition and exercise with smoking contributes to osteoporosis, and obesity combined with poor exercise increases back problems and arthritis. – Physician

Aging Population

An elderly community would have these problems. – Community Leader

Infectious Disease

About Immunization & Infectious Diseases

The increase in life expectancy during the 20th century is largely due to improvements in child survival; this increase is associated with reductions in infectious disease mortality, due largely to immunization. However, infectious diseases remain a major cause of illness, disability, and death. Immunization recommendations in the United States currently target 17 vaccine-preventable diseases across the lifespan.

People in the US continue to get diseases that are vaccine-preventable. Viral hepatitis, influenza, and tuberculosis (TB) remain among the leading causes of illness and death across the nation and account for substantial spending on the related consequences of infection.

The infectious disease public health infrastructure, which carries out disease surveillance at the national, state, and local levels, is an essential tool in the fight against newly emerging and re-emerging infectious diseases. Other important defenses against infectious diseases include:

- Proper use of vaccines
- Antibiotics
- Screening and testing guidelines
- Scientific improvements in the diagnosis of infectious disease-related health concerns

Vaccines are among the most cost-effective clinical preventive services and are a core component of any preventive services package. Childhood immunization programs provide a very high return on investment. For example, for each birth cohort vaccinated with the routine immunization schedule, society:

- Saves 33,000 lives.
- Prevents 14 million cases of disease.
- Reduces direct healthcare costs by \$9.9 billion.
- Saves \$33.4 billion in indirect costs.
- Healthy People 2020 (www.healthypeople.gov)

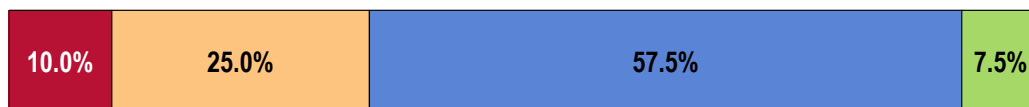
Key Informant Input: Immunization & Infectious Diseases

The following chart outlines key informants' perceptions of the severity of *Immunization & Infectious Diseases* as a problem in the community:

Perceptions of Immunization and Infectious Diseases as a Problem in the Community

(Key Informants, 2017)

■ Major Problem ■ Moderate Problem ■ Minor Problem ■ No Problem At All



Sources: • PRC Online Key Informant Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.

Top Concerns

Among those rating this issue as a “major problem,” reasons related to the following:

Lifestyle

Infectious diseases are a problem, due to individuals not adhering to education and behavior. – Public Health Representative

Health Education

I am not sure the community is ready if an outbreak of an infectious disease were to occur. – Community Leader

Lack of Specialists

No infectious disease specialist. – Physician

Influenza & Pneumonia Vaccination

About Influenza & Pneumonia

Acute respiratory infections, including pneumonia and influenza, are the 8th leading cause of death in the nation, accounting for 56,000 deaths annually. Pneumonia mortality in children fell by 97% in the last century, but respiratory infectious diseases continue to be leading causes of pediatric hospitalization and outpatient visits in the US. On average, influenza leads to more than 200,000 hospitalizations and 36,000 deaths each year. The 2009 H1N1 influenza pandemic caused an estimated 270,000 hospitalizations and 12,270 deaths (1,270 of which were of people younger than age 18) between April 2009 and March 2010.

- Healthy People 2020 (www.healthypeople.gov)

Flu Vaccinations

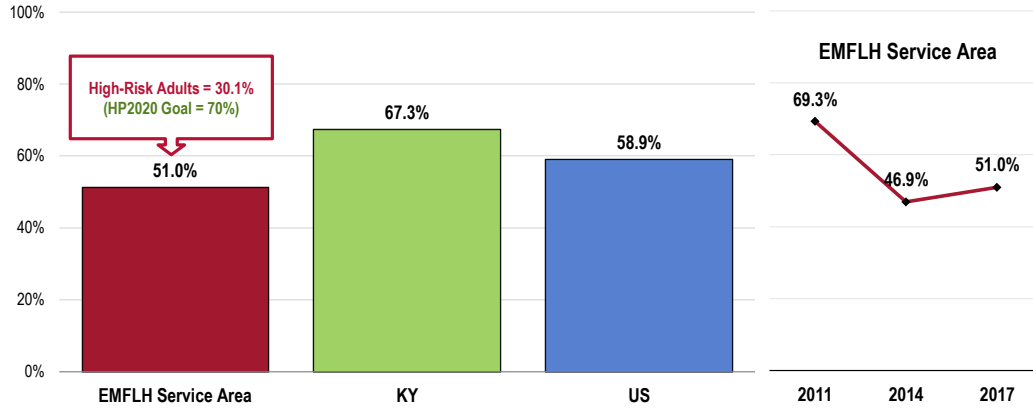
“During the past 12 months, have you had a seasonal flu shot?”

“A pneumonia shot or pneumococcal vaccine is usually given only once or twice in a person’s lifetime and is different from the seasonal flu shot. Have you ever had a pneumonia shot?”

Columns in the following chart show these findings among those age 65+. Percentages for “high-risk” adults age 18-64 in EMFLH Service Area are also shown; here, “high-risk” includes adults who report having been diagnosed with heart disease, diabetes or respiratory disease.

Older Adults: Have Had a Flu Vaccination in the Past Year (Among Adults Age 65+)

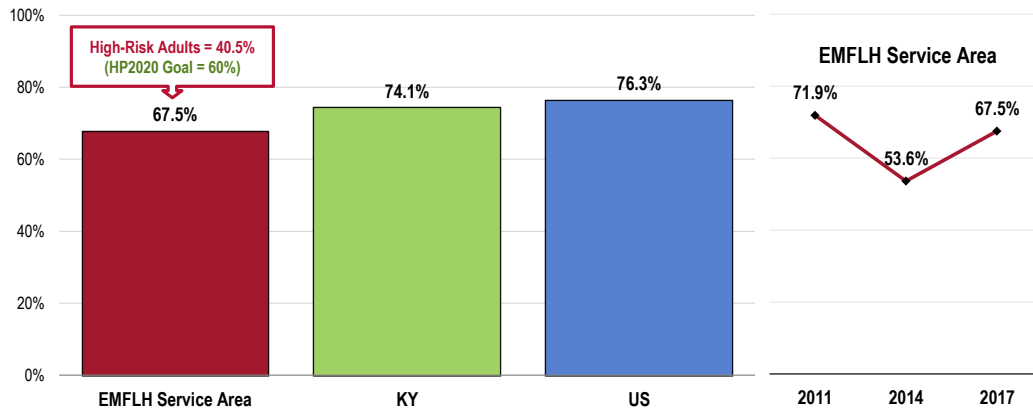
Healthy People 2020 Target = 70.0% or Higher



- Sources:
- 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 163-164]
 - 2015 PRC National Health Survey, Professional Research Consultants, Inc.
 - Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2015 KY data.
 - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective IID-12.12]
- Notes:
- Reflects respondents 65 and older.
 - "High-Risk" includes adults age 18 to 64 who have been diagnosed with heart disease, diabetes or respiratory disease.
 - Includes FluMist as a form of vaccination.

Older Adults: Have Ever Had a Pneumonia Vaccine (Among Adults Age 65+)

Healthy People 2020 Target = 90.0% or Higher



- Sources:
- 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 165-166]
 - 2015 PRC National Health Survey, Professional Research Consultants, Inc.
 - Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2015 KY data.
 - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objectives IID-13.1, IID-13.2]
- Notes:
- Reflects respondents 65 and older.
 - "High-Risk" includes adults age 18 to 64 who have been diagnosed with heart disease, diabetes or respiratory disease.

HIV

About HIV

The HIV epidemic in the United States continues to be a major public health crisis. An estimated 1.1 million Americans are living with HIV, and 1 in 5 people with HIV do not know they have it. HIV continues to spread, leading to about 56,000 new HIV infections each year.

HIV is a preventable disease, and effective HIV prevention interventions have been proven to reduce HIV transmission. People who get tested for HIV and learn that they are infected can make significant behavior changes to improve their health and reduce the risk of transmitting HIV to their sex or drug-using partners. More than 50% of new HIV infections occur as a result of the 21% of people who have HIV but do not know it.

In the era of increasingly effective treatments for HIV, people with HIV are living longer, healthier, and more productive lives. Deaths from HIV infection have greatly declined in the United States since the 1990s. As the number of people living with HIV grows, it will be more important than ever to increase national HIV prevention and healthcare programs.

There are gender, race, and ethnicity disparities in new HIV infections:

- Nearly 75% of new HIV infections occur in men.
- More than half occur in gay and bisexual men, regardless of race or ethnicity.
- 45% of new HIV infections occur in African Americans, 35% in whites, and 17% in Hispanics.

Improving access to quality healthcare for populations disproportionately affected by HIV, such as persons of color and gay and bisexual men, is a fundamental public health strategy for HIV prevention. People getting care for HIV can receive:

- Antiretroviral therapy
- Screening and treatment for other diseases (such as sexually transmitted infections)
- HIV prevention interventions
- Mental health services
- Other health services

As the number of people living with HIV increases and more people become aware of their HIV status, prevention strategies that are targeted specifically for HIV-infected people are becoming more important. Prevention work with people living with HIV focuses on:

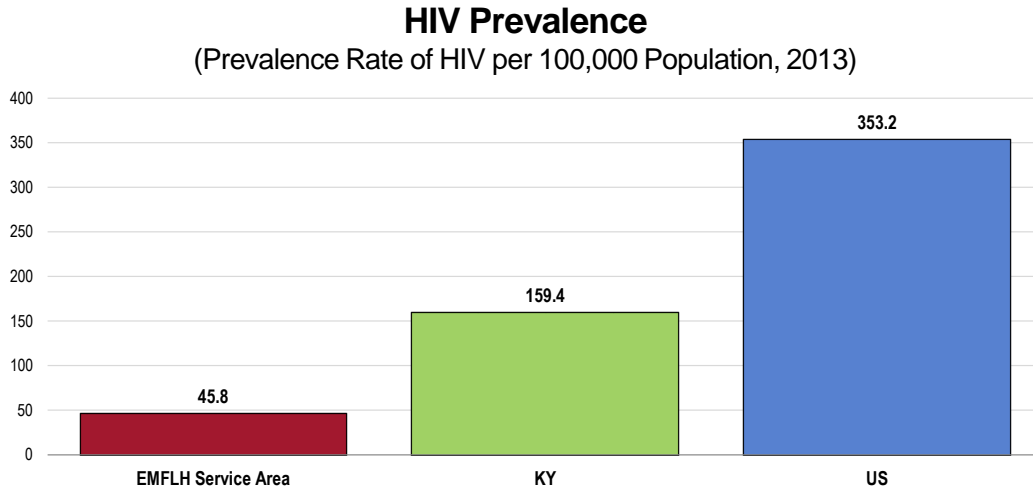
- Linking to and staying in treatment.
- Increasing the availability of ongoing HIV prevention interventions.
- Providing prevention services for their partners.

Public perception in the US about the seriousness of the HIV epidemic has declined in recent years. There is evidence that risky behaviors may be increasing among uninfected people, especially gay and bisexual men. Ongoing media and social campaigns for the general public and HIV prevention interventions for uninfected persons who engage in risky behaviors are critical.

- Healthy People 2020 (www.healthypeople.gov)

HIV Prevalence

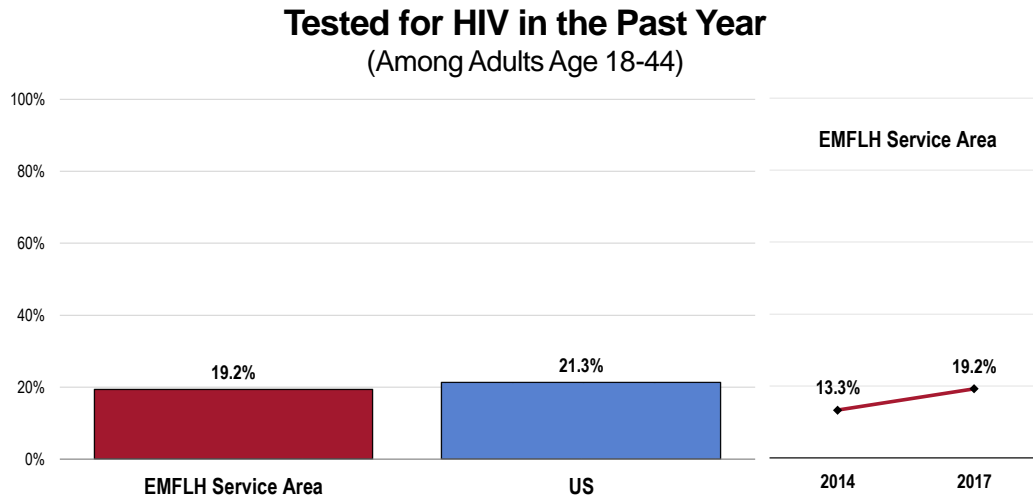
The following chart outlines prevalence (current cases, regardless of when they were diagnosed) of HIV per 100,000 population in the area.



Sources: • Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention.
 • Retrieved March 2017 from Community Commons at <http://www.chna.org>.
 Notes: • This indicator is relevant because HIV is a life-threatening communicable disease that disproportionately affects minority populations and may also indicate the prevalence of unsafe sex practices.

HIV Testing

“Not counting tests you may have had when donating or giving blood, when was the last time you were tested for HIV?” (Reported below only among adults age 18 to 44.)



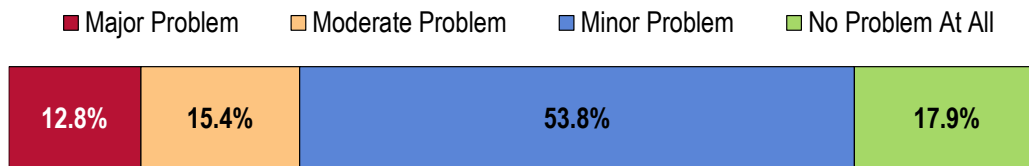
Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 167]
 • 2015 PRC National Health Survey, Professional Research Consultants, Inc.
 Notes: • Reflects respondents age 18 to 44.

Key Informant Input: HIV/AIDS

The following chart outlines key informants' perceptions of the severity of *HIV/AIDS* as a problem in the community:

Perceptions of HIV/AIDS as a Problem in the Community

(Key Informants, 2017)



Sources: • PRC Online Key Informant Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.

Top Concerns

Among those rating this issue as a “major problem,” reasons related to the following:

Health Education

It consumes a disproportionate share of the resources once it is diagnosed. It, too, is lifestyle-related. – Community Leader

There is not a lot of talk on the subject. – Community Leader

Alcohol/Drug Use

Drug abuse, unsafe sexual practices. – Community Leader

Lack of Specialists

No infectious disease specialist. – Physician

Sexually Transmitted Diseases

About Sexually Transmitted Diseases

STDs refer to more than 25 infectious organisms that are transmitted primarily through sexual activity. Despite their burdens, costs, and complications, and the fact that they are largely preventable, STDs remain a significant public health problem in the United States. This problem is largely unrecognized by the public, policymakers, and health care professionals. STDs cause many harmful, often irreversible, and costly clinical complications, such as: reproductive health problems; fetal and perinatal health problems; cancer; and facilitation of the sexual transmission of HIV infection.

Because many cases of STDs go undiagnosed—and some common viral infections, such as human papillomavirus (HPV) and genital herpes, are not reported to CDC at all—the reported cases of chlamydia, gonorrhea, and syphilis represent only a fraction of the true burden of STDs in the US. Untreated STDs can lead to serious long-term health consequences, especially for adolescent girls and young women. Several factors contribute to the spread of STDs.

Biological Factors. STDs are acquired during unprotected sex with an infected partner. Biological factors that affect the spread of STDs include:

- **Asymptomatic nature of STDs.** The majority of STDs either do not produce any symptoms or signs, or they produce symptoms so mild that they are unnoticed; consequently, many infected persons do not know that they need medical care.
- **Gender disparities.** Women suffer more frequent and more serious STD complications than men do. Among the most serious STD complications are pelvic inflammatory disease, ectopic pregnancy (pregnancy outside of the uterus), infertility, and chronic pelvic pain.
- **Age disparities.** Compared to older adults, sexually active adolescents ages 15 to 19 and young adults ages 20 to 24 are at higher risk for getting STDs.
- **Lag time between infection and complications.** Often, a long interval, sometimes years, occurs between acquiring an STD and recognizing a clinically significant health problem.

Social, Economic and Behavioral Factors. The spread of STDs is directly affected by social, economic, and behavioral factors. Such factors may cause serious obstacles to STD prevention due to their influence on social and sexual networks, access to and provision of care, willingness to seek care, and social norms regarding sex and sexuality. Among certain vulnerable populations, historical experience with segregation and discrimination exacerbates these factors. Social, economic, and behavioral factors that affect the spread of STDs include: racial and ethnic disparities; poverty and marginalization; access to healthcare; substance abuse; sexuality and secrecy (stigma and discomfort discussing sex); and sexual networks (persons “linked” by sequential or concurrent sexual partners).

- Healthy People 2020 (www.healthypeople.gov)

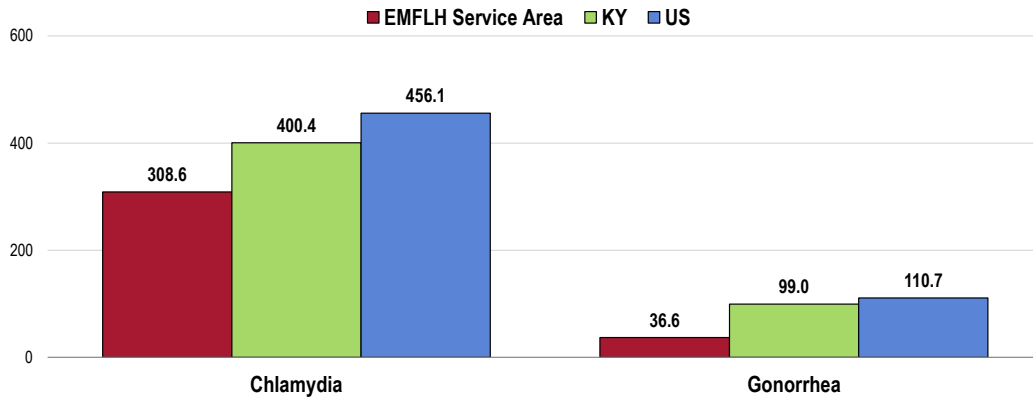
Chlamydia & Gonorrhea

Chlamydia. Chlamydia is the most commonly reported STD in the United States; most people who have chlamydia don’t know it since the disease often has no symptoms.

Gonorrhea. Anyone who is sexually active can get gonorrhea. Gonorrhea can be cured with the right medication; left untreated, however, gonorrhea can cause serious health problems in both women and men.

The following chart outlines local incidence for these STDs.

Chlamydia & Gonorrhea Incidence (Incidence Rate per 100,000 Population, 2014)



Sources: • Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention.
 • Retrieved March 2017 from Community Commons at <http://www.chna.org>.
 Notes: • This indicator is relevant because it is a measure of poor health status and indicates the prevalence of unsafe sex practices.

Safe Sexual Practices

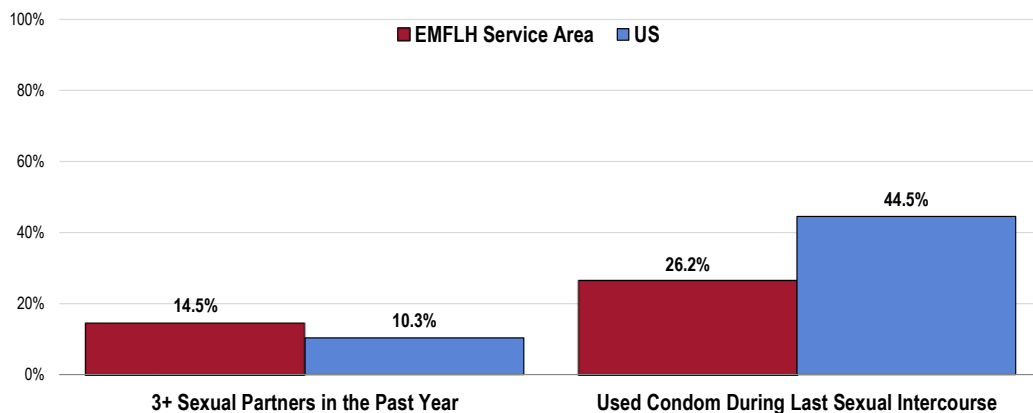
Sexual Partners

“During the past 12 months, with how many people have you had sexual intercourse?”

“Was a condom used the last time you had sexual intercourse?”

Each of these is reported below only among adults who are unmarried and between the ages of 18 and 64.

Sexual Risk (Unmarried Adults Age 18-64)

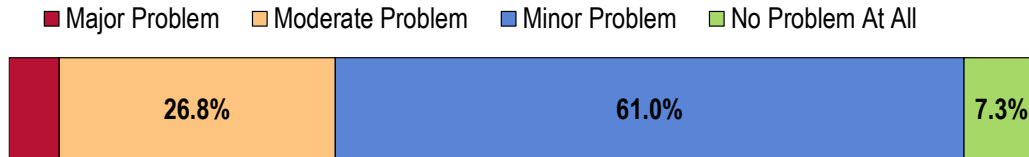


Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 97-98]
 • 2015 PRC National Health Survey, Professional Research Consultants, Inc.
 Notes: • Reflects unmarried respondents under the age of 65.

Key Informant Input: Sexually Transmitted Diseases

The following chart outlines key informants' perceptions of the severity of *Sexually Transmitted Diseases* as a problem in the community:

Perceptions of Sexually Transmitted Diseases as a Problem in the Community (Key Informants, 2017)



Sources: • PRC Online Key Informant Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.

Top Concerns

Among those rating this issue as a “major problem,” reasons related to the following:

Denial/Stigma

Reluctance to get proper treatment. Reluctance to reveal possible sources of infections. – Community Leader

Prevalence/Incidence

Diagnosis of sexually transmitted diseases. – Public Health Representative

Births

About Infant & Child Health

Improving the well-being of mothers, infants, and children is an important public health goal for the US. Their well-being determines the health of the next generation and can help predict future public health challenges for families, communities, and the healthcare system. The risk of maternal and infant mortality and pregnancy-related complications can be reduced by increasing access to quality preconception (before pregnancy) and inter-conception (between pregnancies) care. Moreover, healthy birth outcomes and early identification and treatment of health conditions among infants can prevent death or disability and enable children to reach their full potential. Many factors can affect pregnancy and childbirth, including pre-conception health status, age, access to appropriate healthcare, and poverty.

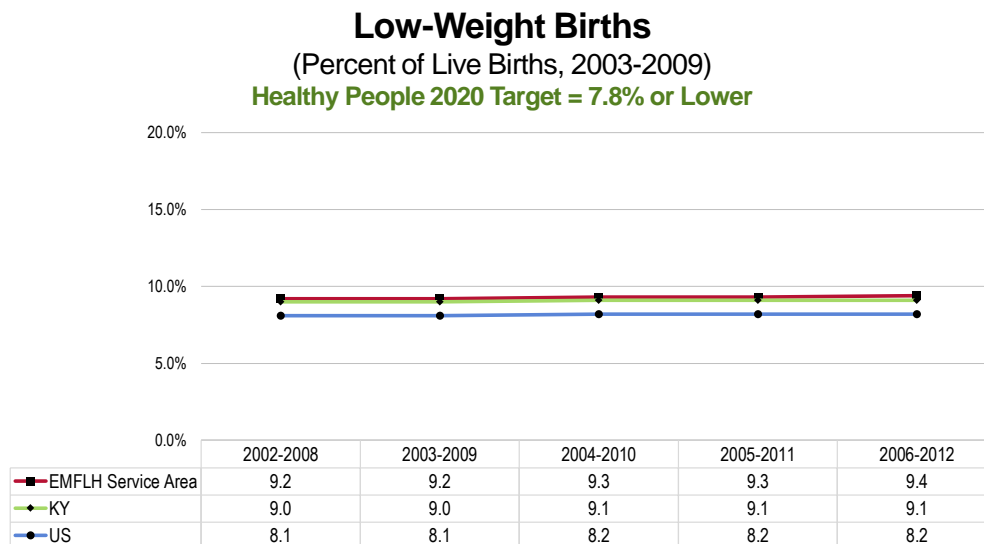
Infant and child health are similarly influenced by socio-demographic factors, such as family income, but are also linked to the physical and mental health of parents and caregivers. There are racial and ethnic disparities in mortality and morbidity for mothers and children, particularly for African Americans. These differences are likely the result of many factors, including social determinants (such as racial and ethnic disparities in infant mortality; family income; educational attainment among household members; and health insurance coverage) and physical determinants (i.e., the health, nutrition, and behaviors of the mother during pregnancy and early childhood).

- Healthy People 2020 (www.healthypeople.gov)

Birth Outcomes & Risks

Low-Weight Births

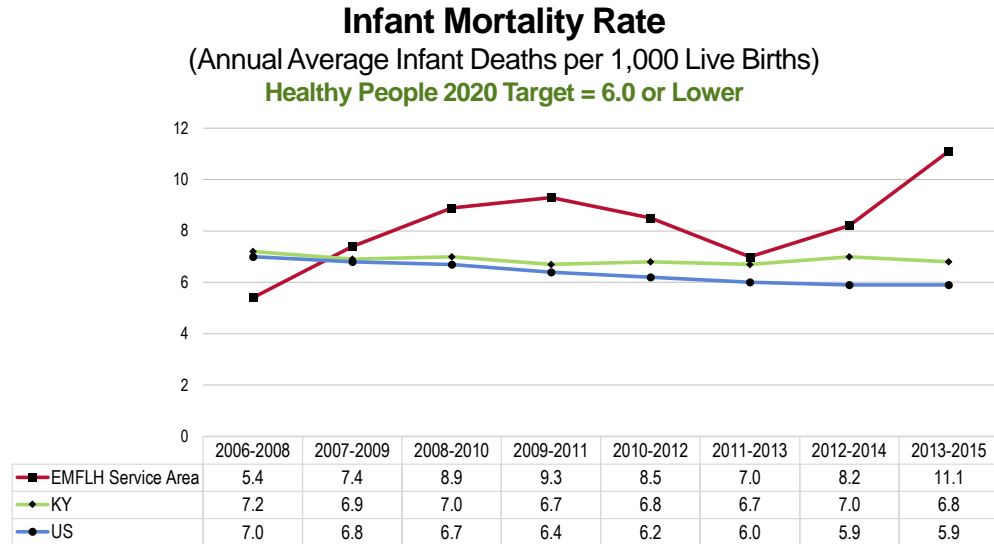
Low birthweight babies, those who weigh less than 2,500 grams (5 pounds, 8 ounces) at birth, are much more prone to illness and neonatal death than are babies of normal birthweight. Largely a result of receiving poor or inadequate prenatal care, many low-weight births and the consequent health problems are preventable. Births of low-weight infants are described below.



- Sources:
- Centers for Disease Control and Prevention, National Vital Statistics System: 2002-12. Accessed using CDC WONDER.
 - Retrieved April 2017 from Community Commons at <http://www.chna.org>.
 - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective MICH-8.1]
- Note:
- This indicator reports the percentage of total births that are low birth weight (Under 2500g). This indicator is relevant because low birth weight infants are at high risk for health problems. This indicator can also highlight the existence of health disparities.

Infant Mortality

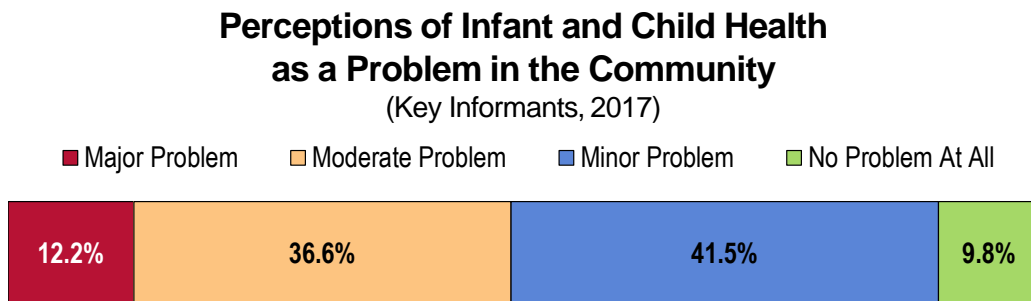
Infant mortality rates reflect deaths of children less than one year old per 1,000 live births. These rates are outlined in the following chart.



Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted March 2017.
 ● Centers for Disease Control and Prevention, National Center for Health Statistics.
 ● US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective MICH-1.3]
 Notes: ● Rates are three-year averages of deaths of children under 1 year old per 1,000 live births.

Key Informant Input: Infant & Child Health

The following chart outlines key informants' perceptions of the severity of *Infant & Child Health* as a problem in the community:



Sources: ● PRC Online Key Informant Survey, Professional Research Consultants, Inc.
 Notes: ● Asked of all respondents.

Top Concerns

Among those rating this issue as a “major problem,” reasons related to the following:

Poverty

A vulnerable population, whose caregivers are typically the least able to pay for health care. – Community Leader
Poverty, lack of affordable medical assistance. – Community Leader

Family Planning

Births to Teen Mothers

About Teen Births

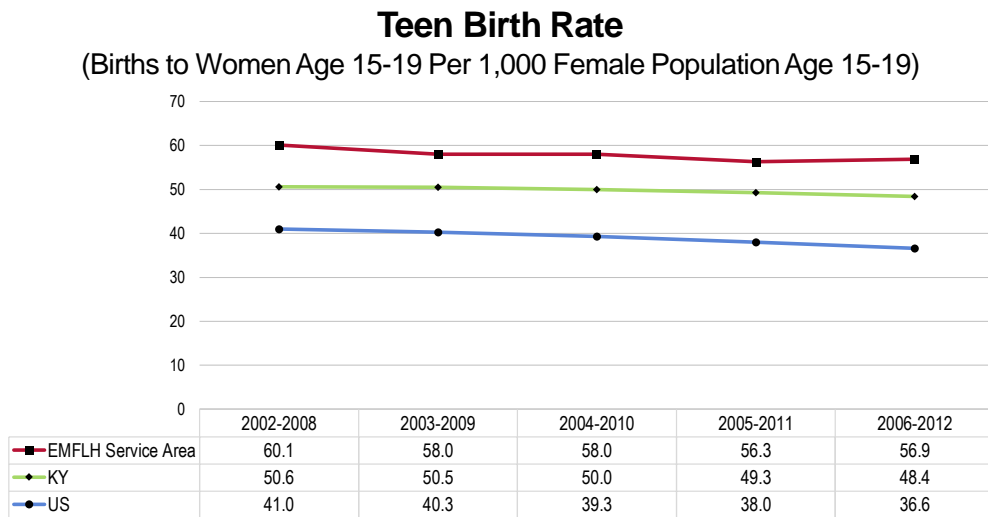
The negative outcomes associated with unintended pregnancies are compounded for adolescents. Teen mothers:

- Are less likely to graduate from high school or attain a GED by the time they reach age 30.
- Earn an average of approximately \$3,500 less per year, when compared with those who delay childbearing.
- Receive nearly twice as much Federal aid for nearly twice as long.

Similarly, early fatherhood is associated with lower educational attainment and lower income. Children of teen parents are more likely to have lower cognitive attainment and exhibit more behavior problems. Sons of teen mothers are more likely to be incarcerated, and daughters are more likely to become adolescent mothers.

- Healthy People 2020 (www.healthypeople.gov)

The following chart describes local teen births.



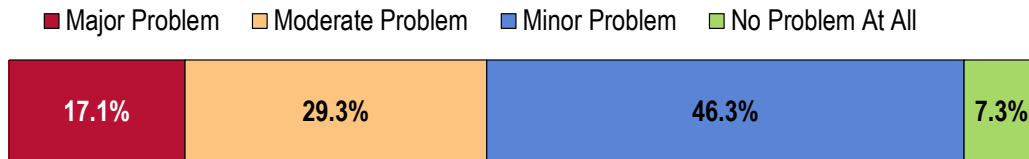
Sources: • Centers for Disease Control and Prevention, National Vital Statistics System. Accessed using CDC WONDER.
 • Retrieved March 2017 from Community Commons at <http://www.chna.org>.

Notes: • This indicator reports the rate of total births to women under the age of 15-19 per 1,000 female population age 15-19. This indicator is relevant because in many cases, teen parents have unique social, economic, and health support services. Additionally, high rates of teen pregnancy may indicate the prevalence of unsafe sex practices.

Key Informant Input: Family Planning

The following chart outlines key informants' perceptions of the severity of *Family Planning* as a problem in the community:

Perceptions of Family Planning as a Problem in the Community (Key Informants, 2017)



Sources: • PRC Online Key Informant Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.

Top Concerns

Among those rating this issue as a “major problem,” reasons related to the following:

Socioeconomic Status

I see and hear about too many families on some form of public assistance and are in the court systems. This tells me people aren't taking care of their families. – Community Leader

Children being born into poverty. – Community Leader

Access to Care/Services

No Planned Parenthood clinics, very little school participation. – Community Leader

Lack of Providers

Few doctors in the area. – Public Health Representative

Modifiable Health Risks

Actual Causes Of Death

About Contributors to Mortality

A 1999 study (an update to a landmark 1993 study), estimated that as many as 40% of premature deaths in the United States are attributed to behavioral factors. This study found that behavior patterns represent the single-most prominent domain of influence over health prospects in the United States. The daily choices we make with respect to diet, physical activity, and sex; the substance abuse and addictions to which we fall prey; our approach to safety; and our coping strategies in confronting stress are all important determinants of health.

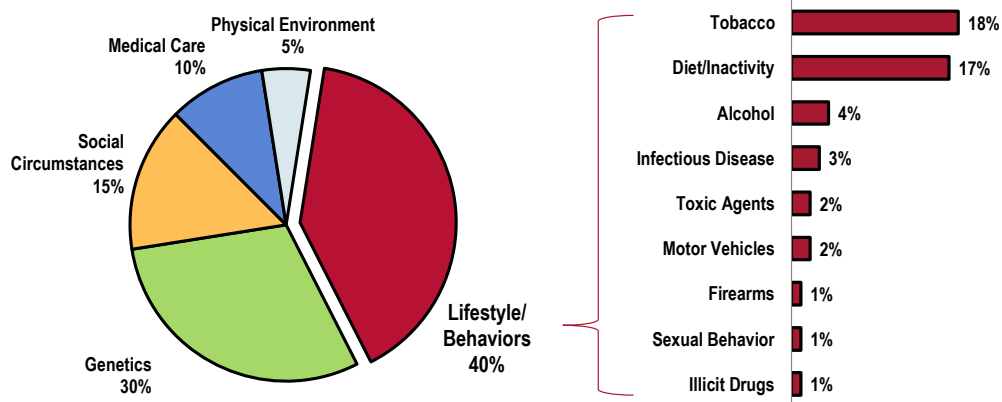
The most prominent contributors to mortality in the United States in 2000 were **tobacco** (an estimated 435,000 deaths), **diet and activity** patterns (400,000), **alcohol** (85,000), **microbial agents** (75,000), **toxic agents** (55,000), **motor vehicles** (43,000), **firearms** (29,000), **sexual behavior** (20,000), and **illicit use of drugs** (17,000). Socioeconomic status and access to medical care are also important contributors, but difficult to quantify independent of the other factors cited. Because the studies reviewed used different approaches to derive estimates, the stated numbers should be viewed as first approximations.

These analyses show that smoking remains the leading cause of mortality. However, poor diet and physical inactivity may soon overtake tobacco as the leading cause of death. These findings, along with escalating healthcare costs and aging population, argue persuasively that the need to establish a more preventive orientation in the US healthcare and public health systems has become more urgent.

- Ali H. Mokdad, PhD; James S. Marks, MD, MPH; Donna F. Stroup, PhD, MSc; Julie L. Gerberding, MD, MPH. "Actual Causes of Death in the United States." JAMA, 291(2004):1238-1245.

While causes of death are typically described as the diseases or injuries immediately precipitating the end of life, a few important studies have shown that the actual causes of premature death (reflecting underlying risk factors) are often preventable.

Factors Contributing to Premature Deaths in the United States



Sources: • "The Case For More Active Policy Attention to Health Promotion"; (McGinnis, Williams-Russo, Knickman) Health Affairs. Vol. 32. No. 2. March/April 2002. "Actual Causes of Death in the United States"; (Ali H. Mokdad, PhD; James S. Marks, MD, MPH; Donna F. Stroup, PhD, MSc; Julie L. Gerberding, MD, MPH.) JAMA. 291 (2000) 1238-1245.

Nutrition, Physical Activity & Weight

Nutrition

About Healthful Diet & Healthy Weight

Strong science exists supporting the health benefits of eating a healthful diet and maintaining a healthy body weight. Efforts to change diet and weight should address individual behaviors, as well as the policies and environments that support these behaviors in settings such as schools, worksites, healthcare organizations, and communities.

The goal of promoting healthful diets and healthy weight encompasses increasing household food security and eliminating hunger.

Americans with a healthful diet:

- Consume a variety of nutrient-dense foods within and across the food groups, especially whole grains, fruits, vegetables, low-fat or fat-free milk or milk products, and lean meats and other protein sources.
- Limit the intake of saturated and trans fats, cholesterol, added sugars, sodium (salt), and alcohol.
- Limit caloric intake to meet caloric needs.

Diet and body weight are related to health status. Good nutrition is important to the growth and development of children. A healthful diet also helps Americans reduce their risks for many health conditions, including: overweight and obesity; malnutrition; iron-deficiency anemia; heart disease; high blood pressure; dyslipidemia (poor lipid profiles); type 2 diabetes; osteoporosis; oral disease; constipation; diverticular disease; and some cancers.

Diet reflects the variety of foods and beverages consumed over time and in settings such as worksites, schools, restaurants, and the home. Interventions to support a healthier diet can help ensure that:

- Individuals have the knowledge and skills to make healthier choices.
- Healthier options are available and affordable.

Social Determinants of Diet. Demographic characteristics of those with a more healthful diet vary with the nutrient or food studied. However, most Americans need to improve some aspect of their diet.

Social factors thought to influence diet include:

- Knowledge and attitudes
- Skills
- Social support
- Societal and cultural norms
- Food and agricultural policies
- Food assistance programs
- Economic price systems

Physical Determinants of Diet. Access to and availability of healthier foods can help people follow healthful diets. For example, better access to retail venues that sell healthier options may have a positive impact on a person's diet; these venues may be less available in low-income or rural neighborhoods.

The places where people eat appear to influence their diet. For example, foods eaten away from home often have more calories and are of lower nutritional quality than foods prepared at home.

Marketing also influences people's—particularly children's—food choices.

- Healthy People 2020 (www.healthypeople.gov)

Daily Recommendation of Fruits/Vegetables

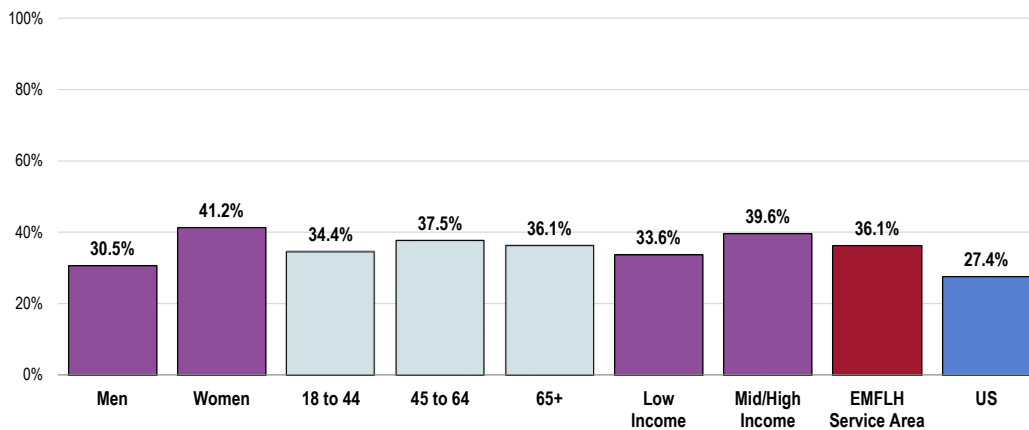
To measure fruit and vegetable consumption, survey respondents were asked multiple questions, specifically about the foods and drinks they consumed on the day prior to the interview.

“Now I would like you to think about the foods you ate or drank yesterday. Include all the foods you ate, both at home and away from home. How many servings of fruit or fruit juices did you have yesterday?”

“How many servings of vegetables did you have yesterday?”

The questions above are used to calculate daily fruit/vegetable consumption for adults at the respondent level. The proportion reporting having 5 or more servings per day is shown below.

Consume Five or More Servings of Fruits/Vegetables Per Day
(EMFLH Service Area, 2017)

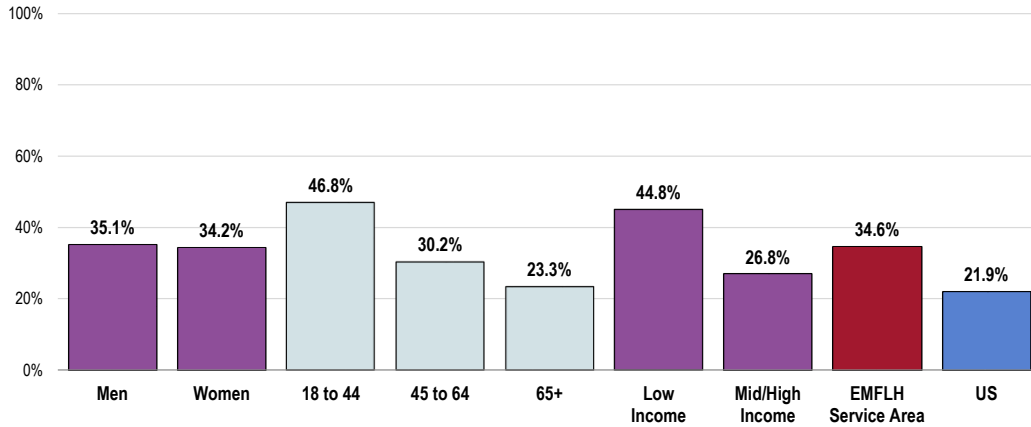


- Sources:
- 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 168]
- Notes:
- Asked of all respondents.
 - Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.
 - For this issue, respondents were asked to recall their food intake on the previous day.

Access to Fresh Produce

“How difficult is it for you to buy fresh produce like fruits and vegetables at a price you can afford — would you say: very difficult, somewhat difficult, not too difficult, or not at all difficult?”

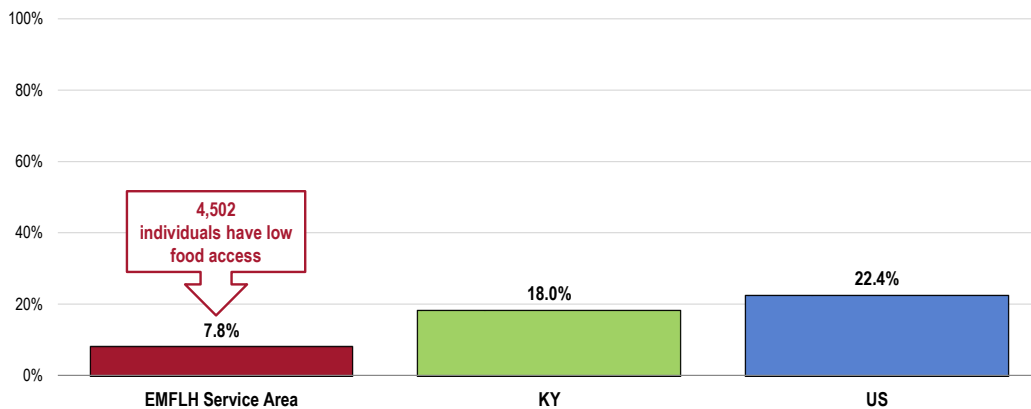
Find It “Very” or “Somewhat” Difficult to Buy Affordable Fresh Produce (EMFLH Service Area, 2017)



Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 103]
 Notes: • Asked of all respondents.
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

A food desert is defined as a low-income area where a significant number or share of residents is far from a supermarket, where "far" is more than 1 mile in urban areas and more than 10 miles in rural areas. The chart for this indicator below is based on US Department of Agriculture data.

Population With Low Food Access (Percent of Population That Is Far From a Supermarket or Large Grocery Store, 2015)



Sources: • US Department of Agriculture, Economic Research Service, USDA - Food Access Research Atlas (FARA).
 • Retrieved March 2017 from Community Commons at <http://www.chna.org>.
 Notes: • This indicator reports the percentage of the population living in census tracts designated as food deserts. A food desert is defined as low-income areas where a significant number or share of residents is far from a supermarket, where "far" is more than 1 mile in urban areas and more than 10 miles in rural areas. This indicator is relevant because it highlights populations and geographies facing food insecurity.

Physical Activity

About Physical Activity

Regular physical activity can improve the health and quality of life of Americans of all ages, regardless of the presence of a chronic disease or disability. Among adults and older adults, physical activity can lower the risk of: early death; coronary heart disease; stroke; high blood pressure; type 2 diabetes; breast and colon cancer; falls; and depression. Among children and adolescents, physical activity can: improve bone health; improve cardiorespiratory and muscular fitness; decrease levels of body fat; and reduce symptoms of depression. For people who are inactive, even small increases in physical activity are associated with health benefits.

Personal, social, economic, and environmental factors all play a role in physical activity levels among youth, adults, and older adults. Understanding the barriers to and facilitators of physical activity is important to ensure the effectiveness of interventions and other actions to improve levels of physical activity.

Factors **positively** associated with adult physical activity include: postsecondary education; higher income; enjoyment of exercise; expectation of benefits; belief in ability to exercise (self-efficacy); history of activity in adulthood; social support from peers, family, or spouse; access to and satisfaction with facilities; enjoyable scenery; and safe neighborhoods.

Factors **negatively** associated with adult physical activity include: advancing age; low income; lack of time; low motivation; rural residency; perception of great effort needed for exercise; overweight or obesity; perception of poor health; and being disabled. Older adults may have additional factors that keep them from being physically active, including lack of social support, lack of transportation to facilities, fear of injury, and cost of programs.

Among children ages 4 to 12, the following factors have a positive association with physical activity: gender (boys); belief in ability to be active (self-efficacy); and parental support.

Among adolescents ages 13 to 18, the following factors have a positive association with physical activity: parental education; gender (boys); personal goals; physical education/school sports; belief in ability to be active (self-efficacy); and support of friends and family.

Environmental influences positively associated with physical activity among children and adolescents include:

- Presence of sidewalks
- Having a destination/walking to a particular place
- Access to public transportation
- Low traffic density
- Access to neighborhood or school play area and/or recreational equipment

People with disabilities may be less likely to participate in physical activity due to physical, emotional, and psychological barriers. Barriers may include the inaccessibility of facilities and the lack of staff trained in working with people with disabilities.

- Healthy People 2020 (www.healthypeople.gov)

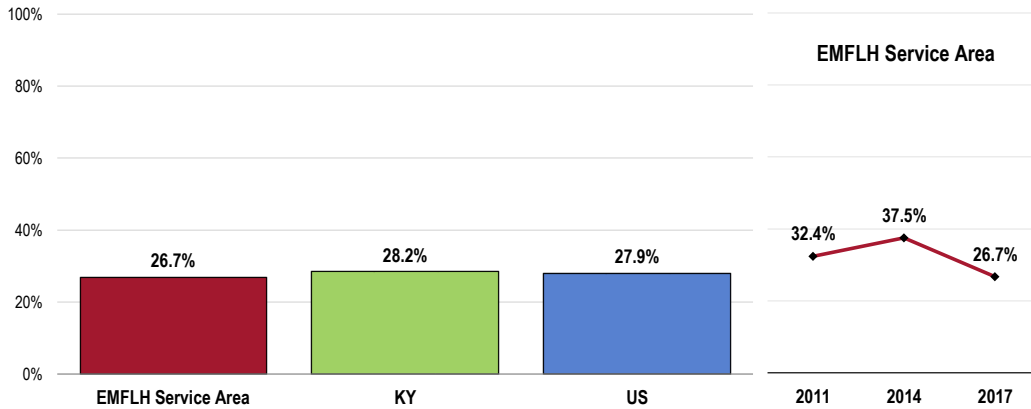
Leisure-Time Physical Activity

Leisure-time physical activity includes any physical activities or exercises (such as running, calisthenics, golf, gardening, walking, etc.) which take place outside of one's line of work.

“During the past month, other than your regular job, did you participate in any physical activities or exercises, such as running, calisthenics, golf, gardening, or walking for exercise?”

No Leisure-Time Physical Activity in the Past Month

Healthy People 2020 Target = 32.6% or Lower



Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 106]
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2015 KY data.
 • 2015 PRC National Health Survey, Professional Research Consultants, Inc.
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective PA-1]

Notes: • Asked of all respondents.

Recommended Levels of Physical Activity

Adults should do 2 hours and 30 minutes a week of moderate-intensity (such as walking), or 1 hour and 15 minutes (75 minutes) a week of vigorous-intensity aerobic physical activity (such as jogging), or an equivalent combination of moderate- and vigorous-intensity aerobic physical activity. The guidelines also recommend that adults do muscle-strengthening activities, such as push-ups, sit-ups, or activities using resistance bands or weights. These activities should involve all major muscle groups and be done on two or more days per week.

The report finds that nationwide nearly 50 percent of adults are getting the recommended amounts of aerobic activity and about 30 percent are engaging in the recommended muscle-strengthening activity.

- 2013 Physical Activity Guidelines for Americans, US Department of Health and Human Services. www.cdc.gov/physicalactivity

Meeting Physical Activity Recommendations

To measure physical activity frequency, duration and intensity, respondents were asked:

“During the past month, what type of physical activity or exercise did you spend the most time doing?”

“And during the past month, how many times per week or per month did you take part in this activity?”

“And when you took part in this activity, for how many minutes or hours did you usually keep at it?”

Respondents could answer the above series for up to two types of physical activity. The specific activities identified (e.g., jogging, basketball, treadmill, etc.) determined the intensity values assigned to that respondent when calculating total aerobic physical activity hours/minutes.

Respondents were also asked about strengthening exercises:

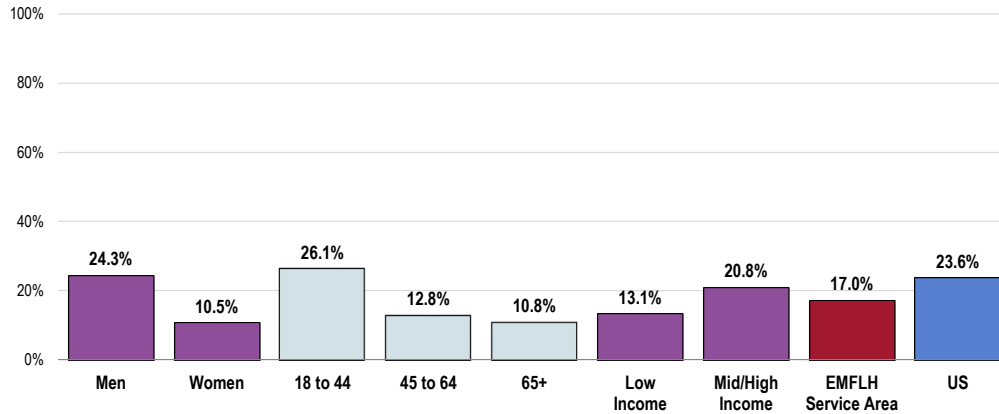
“During the past month, how many times per week or per month did you do physical activities or exercises to strengthen your muscles? Do not count aerobic activities like walking, running, or bicycling. Please include activities using your own body weight, such as yoga, sit-ups or push-ups, and those using weight machines, free weights, or elastic bands.”

“Meeting physical activity recommendations” includes adequate levels of both aerobic and strengthening activity:

- Aerobic activity is at least 150 minutes per week of light to moderate activity or 75 minutes per week of vigorous physical activity or an equivalent combination of both; and
- Strengthening activity is at least 2 sessions per week of exercise designed to strengthen muscles.

Meets Physical Activity Recommendations (EMFLH Service Area, 2017)

Healthy People 2020 Target = 20.1% or Higher

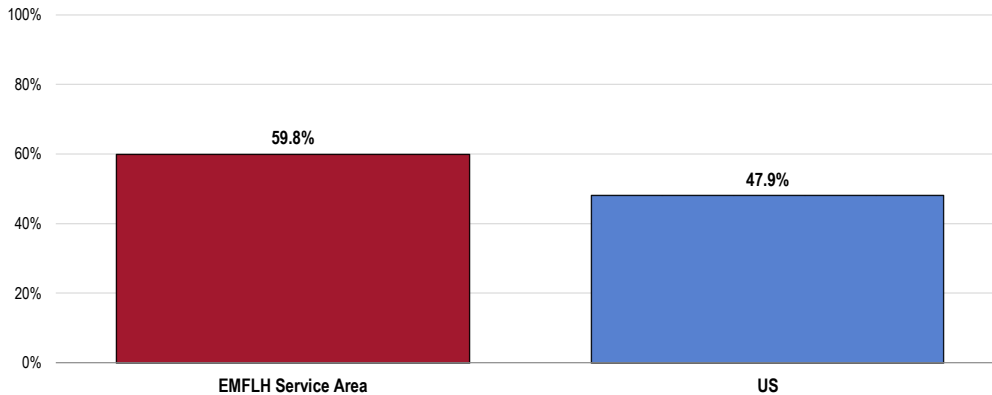


Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 174]
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective PA-2.4]
 Notes: • Asked of all respondents.
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.
 • Meeting both guidelines is defined as the number of persons age 18+ who report light or moderate aerobic activity for at least 150 minutes per week or who report vigorous physical activity 75 minutes per week or an equivalent combination of moderate and vigorous-intensity activity and report doing physical activities specifically designed to strengthen muscles at least twice per week.

Children's Physical Activity

“During the past 7 days, on how many days was this child physically active for a total of at least 60 minutes per day?”

Child Is Physically Active for One or More Hours per Day (Among Children Age 2-17)



Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 142]
 • 2015 PRC National Health Survey, Professional Research Consultants, Inc.
 Notes: • Asked of all respondents with children age 2-17 at home.

Weight Status

About Overweight & Obesity

Because weight is influenced by energy (calories) consumed and expended, interventions to improve weight can support changes in diet or physical activity. They can help change individuals' knowledge and skills, reduce exposure to foods low in nutritional value and high in calories, or increase opportunities for physical activity. Interventions can help prevent unhealthy weight gain or facilitate weight loss among obese people. They can be delivered in multiple settings, including healthcare settings, worksites, or schools.

The social and physical factors affecting diet and physical activity (see Physical Activity topic area) may also have an impact on weight. Obesity is a problem throughout the population. However, among adults, the prevalence is highest for middle-aged people and for non-Hispanic black and Mexican American women. Among children and adolescents, the prevalence of obesity is highest among older and Mexican American children and non-Hispanic black girls. The association of income with obesity varies by age, gender, and race/ethnicity.

- Healthy People 2020 (www.healthypeople.gov)

Body Mass Index (BMI), which describes relative weight for height, is significantly correlated with total body fat content. The BMI should be used to assess overweight and obesity and to monitor changes in body weight. In addition, measurements of body weight alone can be used to determine efficacy of weight loss therapy. BMI is calculated as weight (kg)/height squared (m²). To estimate BMI using pounds and inches, use: [weight (pounds)/height squared (inches²)] x 703.

In this report, overweight is defined as a BMI of 25.0 to 29.9 kg/m² and obesity as a BMI ≥30 kg/m². The rationale behind these definitions is based on epidemiological data that show increases in mortality with BMIs above 25 kg/m². The increase in mortality, however, tends to be modest until a BMI of 30 kg/m² is reached. For persons with a BMI ≥30 kg/m², mortality rates from all causes, and especially from cardiovascular disease, are generally increased by 50 to 100 percent above that of persons with BMIs in the range of 20 to 25 kg/m².

- Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: The Evidence Report. National Institutes of Health. National Heart, Lung, and Blood Institute in Cooperation With The National Institute of Diabetes and Digestive and Kidney Diseases. September 1998.

Classification of Overweight and Obesity by BMI	BMI (kg/m ²)
Underweight	<18.5
Healthy Weight	18.5 – 24.9
Overweight, not Obese	25.0 – 29.9
Obese	≥30.0

Source: Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: The Evidence Report. National Institutes of Health. National Heart, Lung, and Blood Institute in Cooperation With The National Institute of Diabetes and Digestive and Kidney Diseases. September 1998.

Adult Weight Status

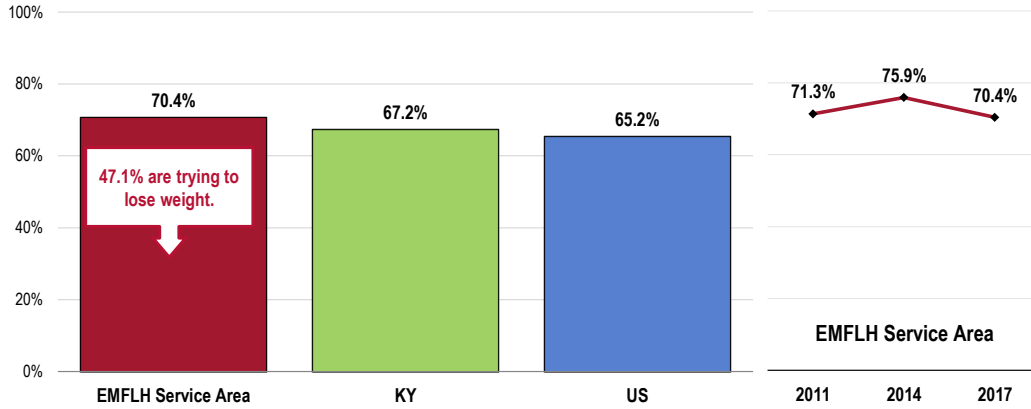
“About how much do you weigh without shoes?”

“About how tall are you without shoes?”

“Are you now trying to lose weight?”

Reported height and weight were used to calculate a Body Mass Index or BMI value (described above) for each respondent. This calculation allows us to examine the proportion of the population who is at a healthy weight, or who is overweight or obese (see table above).

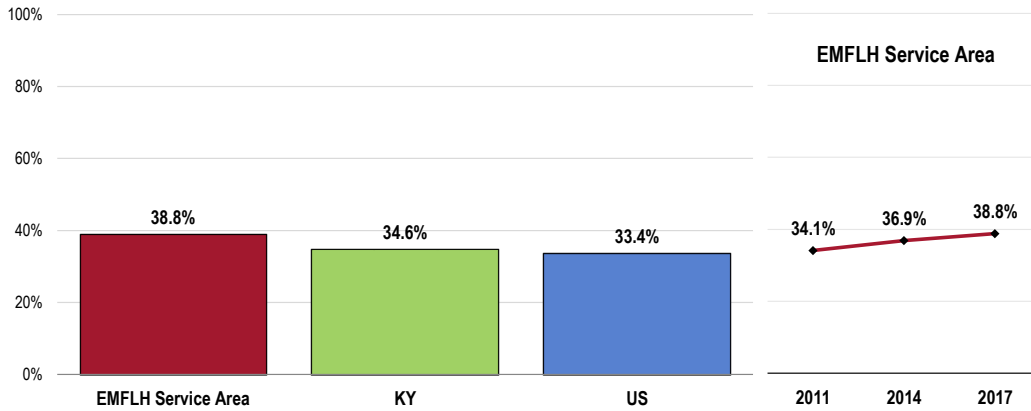
Prevalence of Total Overweight (Percent of Adults With a Body Mass Index of 25.0 or Higher)



Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 176-177]
 • 2015 PRC National Health Survey, Professional Research Consultants, Inc.
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2015 KY data.

Notes: • Based on reported heights and weights, asked of all respondents.
 • The definition of overweight is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 25.0, regardless of gender. The definition for obesity is a BMI greater than or equal to 30.0.

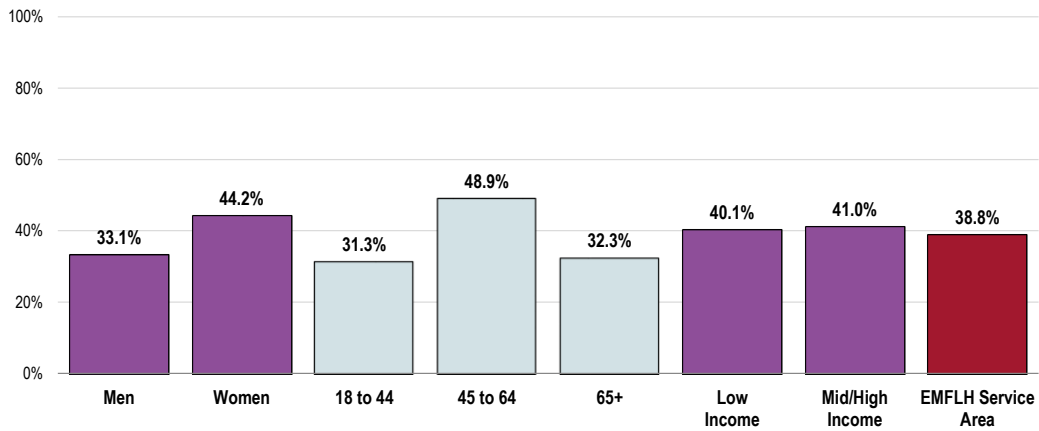
Prevalence of Obesity (Percent of Adults With a Body Mass Index of 30.0 or Higher) Healthy People 2020 Target = 30.5% or Lower



Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 176]
 • 2015 PRC National Health Survey, Professional Research Consultants, Inc.
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective NWS-9]
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2015 KY data.

Notes: • Based on reported heights and weights, asked of all respondents.
 • The definition of obesity is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 30.0, regardless of gender.

Prevalence of Obesity (Percent of Adults With a BMI of 30.0 or Higher; EMFLH Service Area, 2017) Healthy People 2020 Target = 30.5% or Lower



- Sources:
- 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 176]
 - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective NWS-9]
- Notes:
- Based on reported heights and weights, asked of all respondents.
 - Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.
 - The definition of obesity is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 30.0, regardless of gender.

Childhood Overweight & Obesity

About Weight Status in Children & Teens

In children and teens, body mass index (BMI) is used to assess weight status – underweight, healthy weight, overweight, or obese. After BMI is calculated for children and teens, the BMI number is plotted on the CDC BMI-for-age growth charts (for either girls or boys) to obtain a percentile ranking. Percentiles are the most commonly used indicator to assess the size and growth patterns of individual children in the United States. The percentile indicates the relative position of the child's BMI number among children of the same sex and age.

BMI-for-age weight status categories and the corresponding percentiles are shown below:

- Underweight <5th percentile
- Healthy Weight ≥5th and <85th percentile
- Overweight ≥85th and <95th percentile
- Obese ≥95th percentile

- Centers for Disease Control and Prevention

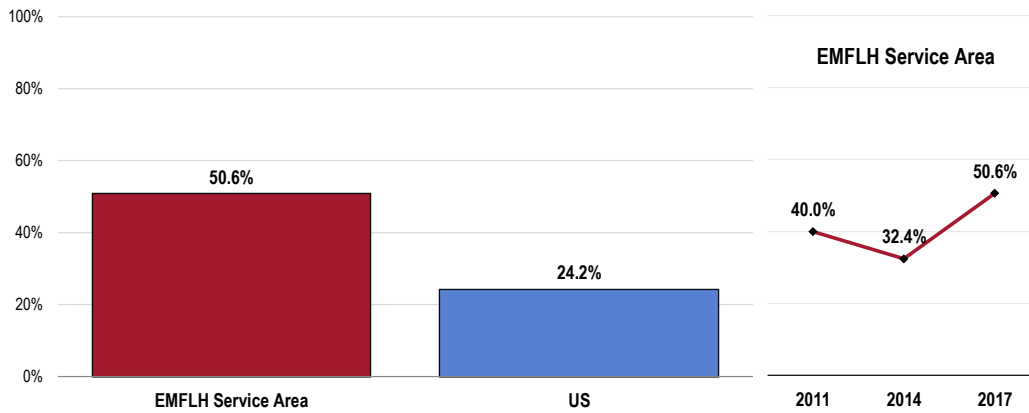
The following questions were used to calculate a BMI value (and weight classification as noted above) for each child represented in the survey:

“How much does this child weigh without shoes?”

“About how tall is this child?”

Child Total Overweight Prevalence

(Children Age 5-17 Who Are Overweight/Obese; BMI in the 85th Percentile or Higher)

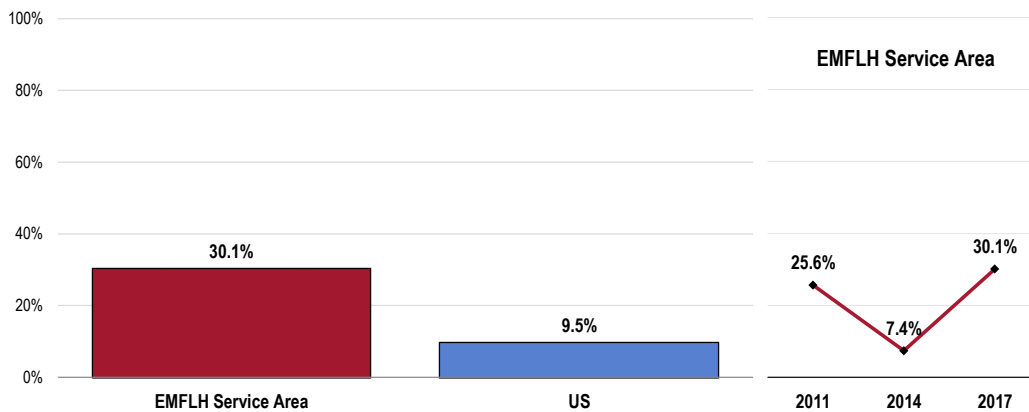


- Sources:
- 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 180]
 - 2015 PRC National Health Survey, Professional Research Consultants, Inc.
- Notes:
- Asked of all respondents with children age 5-17 at home.
 - Overweight among children is determined by children's Body Mass Index status at or above the 85th percentile of US growth charts by gender and age.

Child Obesity Prevalence

(Children Age 5-17 Who Are Obese; BMI in the 95th Percentile or Higher)

Healthy People 2020 Target = 14.5% or Lower



- Sources:
- 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 180]
 - 2015 PRC National Health Survey, Professional Research Consultants, Inc.
 - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective NWS-10.4]
- Notes:
- Asked of all respondents with children age 5-17 at home.
 - Obesity among children is determined by children's Body Mass Index status equal to or above the 95th percentile of US growth charts by gender and age.

Key Informant Input: Nutrition, Physical Activity & Weight

The following chart outlines key informants' perceptions of the severity of *Nutrition, Physical Activity & Weight* as a problem in the community:

Perceptions of Nutrition, Physical Activity, and Weight as a Problem in the Community

(Key Informants, 2017)

■ Major Problem ■ Moderate Problem ■ Minor Problem ■ No Problem At All



Sources: • PRC Online Key Informant Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.

Top Concerns

Among those rating this issue as a “major problem,” reasons related to the following:

Lifestyle

- Sedentary lifestyle, lack of physical education, cheap high sugar and fat foods. – Community Leader*
- Routine health maintenance, supported by regular physician visits and regular exercise and diet programs. – Physician*
- Most of our clients come in with health issues related to improper nutrition and/or lack of physical activity, and most are overweight. – Social Services Provider*
- Sugary drinks. – Community Leader*
- Sedentary lifestyles, lack of exercise, abundance of fast and unhealthy food. – Community Leader*
- Fast food and overeating. – Community Leader*

Access to Healthy Foods

- Finding fresh product, lack of desire, cultural. – Community Leader*
- Behavioral changes. Individuals cannot afford to eat healthy, due to the cost of food items. Lack of motivation to exercise. – Public Health Representative*
- Low-income families not being able to afford the healthier foods selections. Parents allowing children to watch more TV and play video games. Not encouraging them to exercise. – Community Leader*
- Healthy food is costly and time-consuming. It is much easier to pick up fast food, and it's also cheaper. Not enough places to offer free physical activities. – Community Leader*

Obesity

- Kentucky has a high rate of obesity, which results in lots of medical issues. Poor people cannot always afford healthy food. Food low in nutritional value, high in sodium, high in fat content, are often cheaper than fresh foods. – Community Leader*
- Generally speaking, everybody is overweight to some degree. It seems like the fast food vendors want to “supersize” their dinners, and we and our kids are the ones being “supersized”. – Community Leader*
- Increase in obesity. – Social Services Provider*
- Child obesity. More and more affordable fast food establishments. – Community Leader*

Access to Care/Services

- Work schedules conflict with support group schedules. – Community Leader*

Built Environment

- Lack of sidewalks or safe places to ride bikes. Anderson Dean Park not within safe walking distance or safe cycling distance. – Public Health Representative*

Health Education

- Ignorance of the relationship among nutrition, physical activity and weight issues. – Community Leader*

Substance Abuse

About Substance Abuse

Substance abuse has a major impact on individuals, families, and communities. The effects of substance abuse are cumulative, significantly contributing to costly social, physical, mental, and public health problems. These problems include:

- Teenage pregnancy
- Human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS)
- Other sexually transmitted diseases (STDs)
- Domestic violence
- Child abuse
- Motor vehicle crashes
- Physical fights
- Crime
- Homicide
- Suicide

Substance abuse refers to a set of related conditions associated with the consumption of mind- and behavior-altering substances that have negative behavioral and health outcomes. Social attitudes and political and legal responses to the consumption of alcohol and illicit drugs make substance abuse one of the most complex public health issues. In addition to the considerable health implications, substance abuse has been a flash-point in the criminal justice system and a major focal point in discussions about social values: people argue over whether substance abuse is a disease with genetic and biological foundations or a matter of personal choice.

Advances in research have led to the development of evidence-based strategies to effectively address substance abuse. Improvements in brain-imaging technologies and the development of medications that assist in treatment have gradually shifted the research community's perspective on substance abuse. There is now a deeper understanding of substance abuse as a disorder that develops in adolescence and, for some individuals, will develop into a chronic illness that will require lifelong monitoring and care.

Improved evaluation of community-level prevention has enhanced researchers' understanding of environmental and social factors that contribute to the initiation and abuse of alcohol and illicit drugs, leading to a more sophisticated understanding of how to implement evidence-based strategies in specific social and cultural settings.

A stronger emphasis on evaluation has expanded evidence-based practices for drug and alcohol treatment. Improvements have focused on the development of better clinical interventions through research and increasing the skills and qualifications of treatment providers.

- Healthy People 2020 (www.healthypeople.gov)

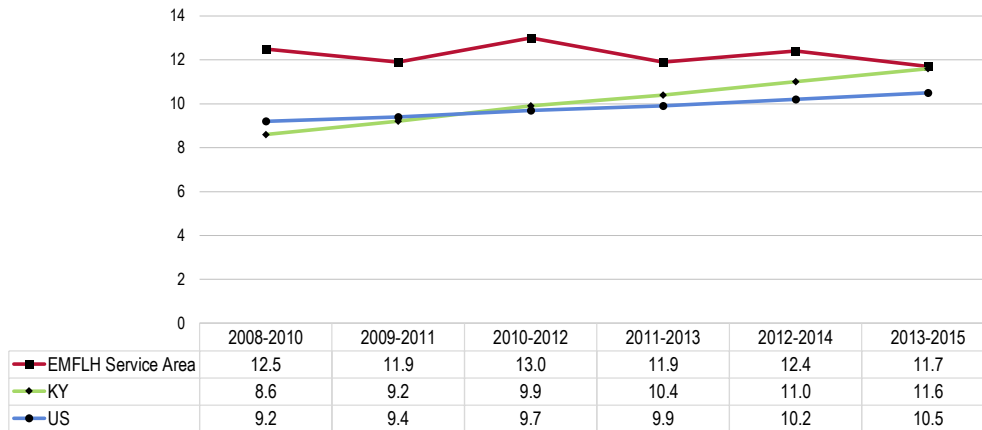
Related Age-Adjusted Mortality

Cirrhosis/Liver Disease. Heavy alcohol use contributes to a significant share of liver disease, including cirrhosis. The chart below outlines age-adjusted mortality for cirrhosis/liver disease in the area.

Drug-Induced Deaths. Drug-induced deaths include all deaths for which drugs are the underlying cause, including those attributable to acute poisoning by drugs (drug overdoses) and deaths from medical conditions resulting from chronic drug use (e.g., drug-induced Cushing's syndrome). A "drug" includes illicit or street drugs (e.g., heroin and cocaine), as well as legal prescription and over-the-counter drugs; alcohol is not included. These deaths may also be either intentional (e.g., suicide) or unintentional (accidental). The following chart outlines local age-adjusted mortality for drug-induced deaths.

Cirrhosis/Liver Disease: Age-Adjusted Mortality Trends (Annual Average Deaths per 100,000 Population)

Healthy People 2020 Target = 8.2 or Lower

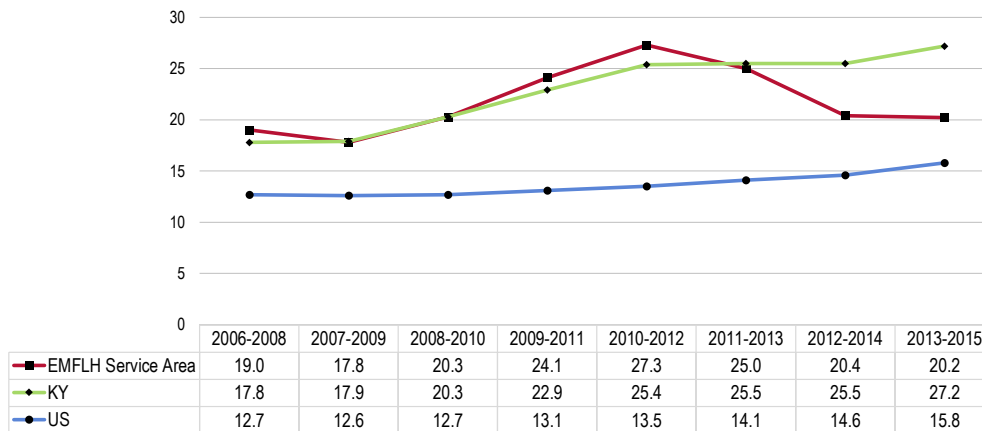


Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted March 2017.
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective SA-11]

Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
 • Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Drug-Induced Deaths: Age-Adjusted Mortality Trends (Annual Average Deaths per 100,000 Population)

Healthy People 2020 Target = 11.3 or Lower



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted March 2017.
 • UD Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective SA-12]

Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
 • Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Alcohol Use

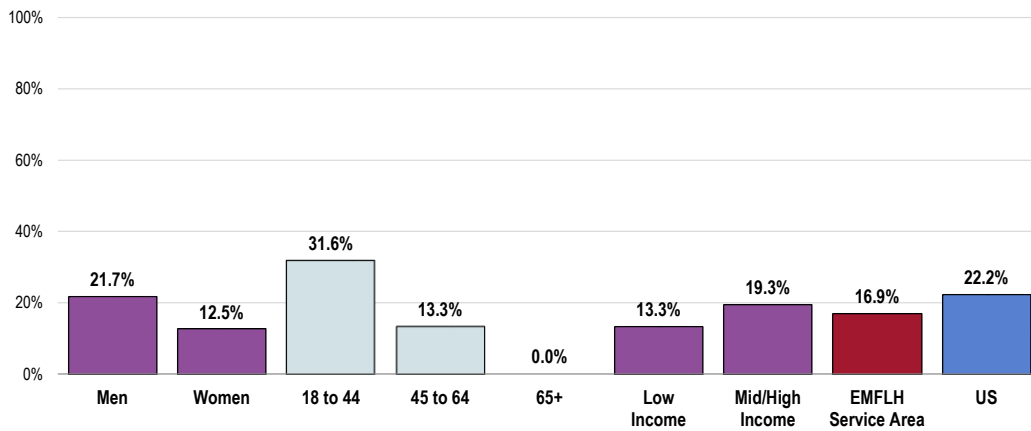
Excessive Drinkers. Excessive drinking reflects the number of persons aged 18 years and over who drank more than two drinks per day on average (for men) or more than one drink per day on average (for women) or who drank 5 or more drinks during a single occasion (for men) or 4 or more drinks during a single occasion (for women) during the past 30 days.

“During the past 30 days, on how many days did you have at least one drink of any alcoholic beverage such as beer, wine, a malt beverage, or liquor?”

“On the day(s) when you drank, about how many drinks did you have on the average?”

“Considering all types of alcoholic beverages, how many times during the past 30 days did you have 5 (if male)/4 (if female) or more drinks on an occasion?”

Excessive Drinkers
(EMFLH Service Area, 2017)
Healthy People 2020 Target = 25.4% or Lower

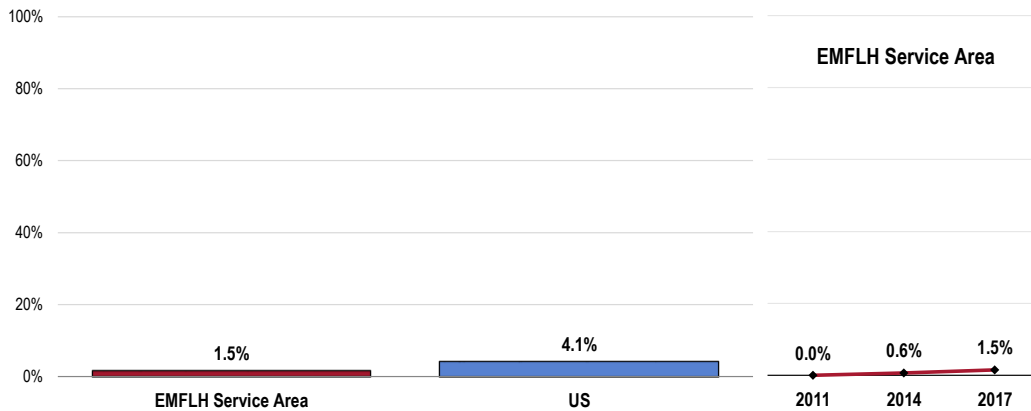


- Sources:
- 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 189]
 - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective SA-15]
- Notes:
- Asked of all respondents.
 - Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.
 - Excessive drinking reflects the number of persons aged 18 years and over who drank more than two drinks per day on average (for men) or more than one drink per day on average (for women) OR who drank 5 or more drinks during a single occasion (for men) or 4 or more drinks during a single occasion (for women) during the past 30 days.

Drinking & Driving. As a self-reported measure – and because this indicator reflects potentially illegal behavior – it is reasonable to expect that it might be underreported, and that the actual incidence of drinking and driving in the community is likely higher.

“During the past 30 days, how many times have you driven when you've had perhaps too much to drink?”

Have Driven in the Past Month After Perhaps Having Too Much to Drink

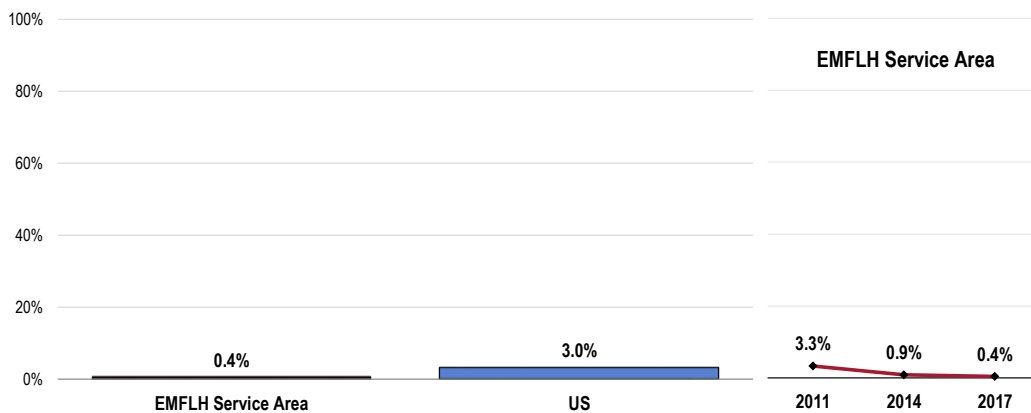


Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 66]
 • 2015 PRC National Health Survey, Professional Research Consultants, Inc.
 Notes: • Asked of all respondents.

Illicit Drug Use

“During the past 30 days, have you used an illegal drug or taken a prescription drug that was not prescribed to you?”

Illicit Drug Use in the Past Month Healthy People 2020 Target = 7.1% or Lower

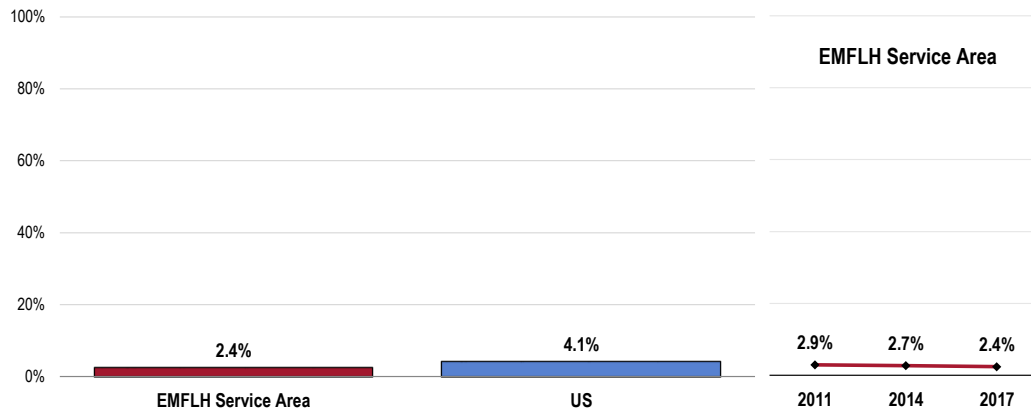


Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 67]
 • 2015 PRC National Health Survey, Professional Research Consultants, Inc.
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective SA-13.3]
 Notes: • Asked of all respondents.

Alcohol & Drug Treatment

“Have you ever sought professional help for an alcohol or drug-related problem?”

Have Ever Sought Professional Help for an Alcohol/Drug-Related Problem

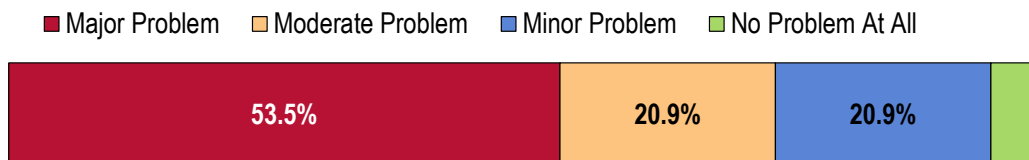


Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 68]
 • 2015 PRC National Health Survey, Professional Research Consultants, Inc.
 Notes: • Asked of all respondents.

Key Informant Input: Substance Abuse

The following chart outlines key informants' perceptions of the severity of *Substance Abuse* as a problem in the community:

Perceptions of Substance Abuse as a Problem in the Community (Key Informants, 2017)



Sources: • PRC Online Key Informant Survey, Professional Research Consultants, Inc.
 Notes: • Asked of all respondents.

Barriers to Treatment

Among those rating this issue as a “major problem,” the greatest barriers to accessing substance abuse treatment are viewed as:

Access to Care/Services

We have few—if any—options for treating substance abuse. And the growing number of addicts makes the demand for comprehensive substance abuse even greater! Jail does not equal treatment. This is a rampant problem in all of Kentucky. Funding is also an issue. If you can get someone into a program, who will pay for it? Few are covered by insurance. – Community Leader

I don't know that there are any barriers in receiving substance abuse (drug addiction) treatment in this community. There are drug court programs, rehab centers, hospitals and other medical facilities in each of the counties in the community, and the drug problem only seems to be getting worse. I'm not sure if removing barriers to health care is the answer to drug addiction or substance abuse. – Community Leader

No centralized programs. Lack of governmental funding for rehab issues. – Community Leader

Very few treatment centers are available. – Community Leader

No local treatment programs. No halfway house to support those out of rehab. – Public Health Representative

We need a treatment center, which would cost a lot of money for both the facility and the staff. Plus, it would have to be affordable. – Community Leader

We currently have a substance abuse facility in my community that is successful with the graduation rate. – Community Leader

No facilities/treatment centers. – Community Leader

Lack of treatment centers. – Public Health Representative

Facilities for rehabilitation. – Community Leader

Long-term care. – Community Leader

Prevalence/Incidence

Drugs are a major problem in this community. I am not sure we have the knowledge or support to combat it effectively. – Community Leader

We have an alarming number of clients who show the signs of substance abuse. – Social Services Provider

Increased numbers in death and overdose. – Social Services Provider

Many overdoses. – Community Leader

Affordable Care/Services

Lack of programs that are affordable and local. – Physician

I'm not sure there are any barriers for addicts that truly want to seek help for their addictions. Maybe the cost of the program would be a barrier to some. – Community Leader

Lack of affordable outpatient and inpatient services. – Public Health Representative

Access to Drugs/Alcohol

Far too many drugs in this area. – Community Leader

Ease and privacy in a small community. – Physician

Denial/Stigma

Programs are available. There needs to be an individual desire to seek help. – Community Leader

Too many folks tolerate in the early stages. Reluctant to hold loved one accountable. – Community Leader

Lack of Funding

Lack of funds. – Community Leader

Funds, understanding, volunteers and law enforcement. – Community Leader

Health Education

Knowing who to go to and fear of cost. – Community Leader

Socioeconomic Status

Social-economic well-being, leading to drugs and mental health issues. – Community Leader

Most Problematic Substances

Key informants (who rated this as a “major problem”) clearly identified **heroin/other opioids** as the most problematic substance abused in the community, followed by **methamphetamine/other amphetamines** and **alcohol**.

Problematic Substances as Identified by Key Informants				
	Most Problematic	Second-Most Problematic	Third-Most Problematic	Total Mentions
Heroin or Other Opioids	70.0%	10.0%	10.0%	18
Methamphetamines or Other Amphetamines	0.0%	55.0%	15.0%	14
Alcohol	15.0%	10.0%	30.0%	11
Prescription Medications	0.0%	15.0%	10.0%	5
Marijuana	0.0%	5.0%	20.0%	5
Cocaine or Crack	5.0%	5.0%	5.0%	3
Synthetic Drugs (e.g. Bath Salts, K2/Spice)	10.0%	0.0%	0.0%	2
Hallucinogens or Dissociative Drugs (e.g. Ketamine, PCP, LSD, DXM)	0.0%	0.0%	5.0%	1
Over-The-Counter Medications	0.0%	0.0%	5.0%	1

Tobacco Use

About Tobacco Use

Tobacco use is the single most preventable cause of death and disease in the United States. Scientific knowledge about the health effects of tobacco use has increased greatly since the first Surgeon General's report on tobacco was released in 1964.

Tobacco use causes:

- Cancer
- Heart disease
- Lung diseases (including emphysema, bronchitis, and chronic airway obstruction)
- Premature birth, low birth weight, stillbirth, and infant death

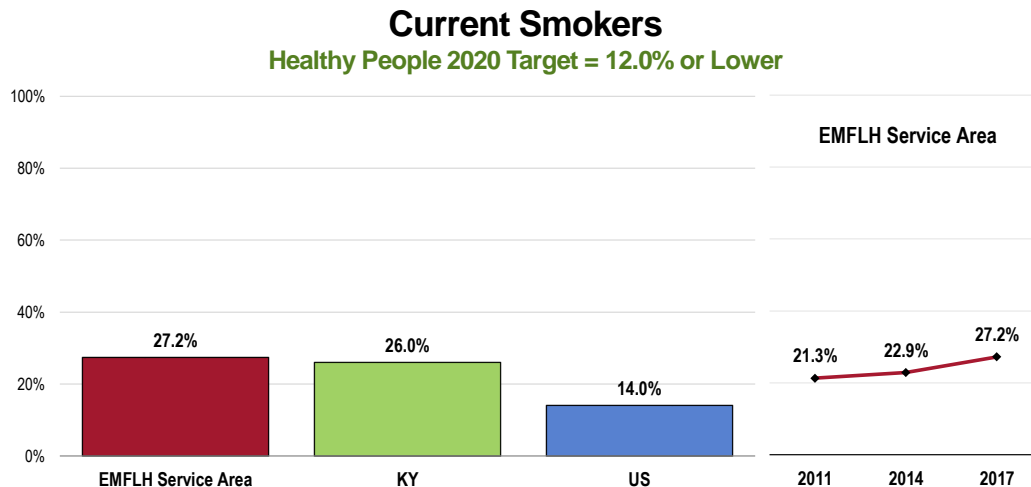
There is no risk-free level of exposure to secondhand smoke. Secondhand smoke causes heart disease and lung cancer in adults and a number of health problems in infants and children, including: severe asthma attacks; respiratory infections; ear infections; and sudden infant death syndrome (SIDS).

Smokeless tobacco causes a number of serious oral health problems, including cancer of the mouth and gums, periodontitis, and tooth loss. Cigar use causes cancer of the larynx, mouth, esophagus, and lung.

- Healthy People 2020 (www.healthypeople.gov)

Cigarette Smoking

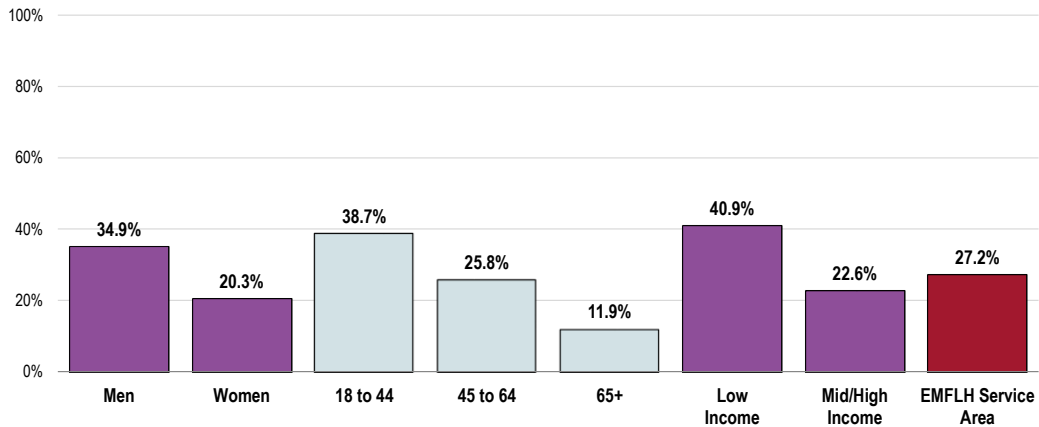
“Do you now smoke cigarettes every day, some days, or not at all?”



- Sources:
- 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 181]
 - 2015 PRC National Health Survey, Professional Research Consultants, Inc.
 - Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2015 KY data.
 - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective TU-1.1]
- Notes:
- Asked of all respondents.
 - Includes regular and occasional smokers (those who smoke cigarettes every day or on some days).

Current Smokers (EMFLH Service Area, 2017)

Healthy People 2020 Target = 12.0% or Lower



- Sources:
- 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 181]
 - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective TU-1.1]
- Notes:
- Asked of all respondents.
 - Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.
 - Includes regular and occasion smokers (every day and some days).

Smoking Cessation

About Reducing Tobacco Use

Preventing tobacco use and helping tobacco users quit can improve the health and quality of life for Americans of all ages. People who stop smoking greatly reduce their risk of disease and premature death. Benefits are greater for people who stop at earlier ages, but quitting tobacco use is beneficial at any age.

Many factors influence tobacco use, disease, and mortality. Risk factors include race/ethnicity, age, education, and socioeconomic status. Significant disparities in tobacco use exist geographically; such disparities typically result from differences among states in smoke-free protections, tobacco prices, and program funding for tobacco prevention.

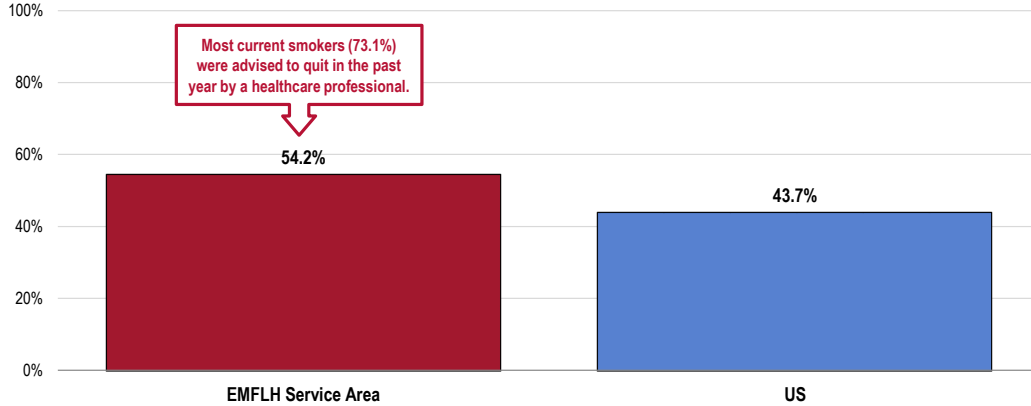
- Healthy People 2020 (www.healthypeople.gov)

**“In the past 12 months, has a doctor, nurse or other health professional advised you to quit smoking?”
(Asked of respondents who smoke every day or on some days.)**

“During the past 12 months, have you stopped smoking for one day or longer because you were trying to quit smoking?” (Asked of respondents who smoke every day.)

Have Stopped Smoking for One Day or Longer in the Past Year in an Attempt to Quit Smoking (Among Everyday Smokers)

Healthy People 2020 Target = 80.0% or Higher



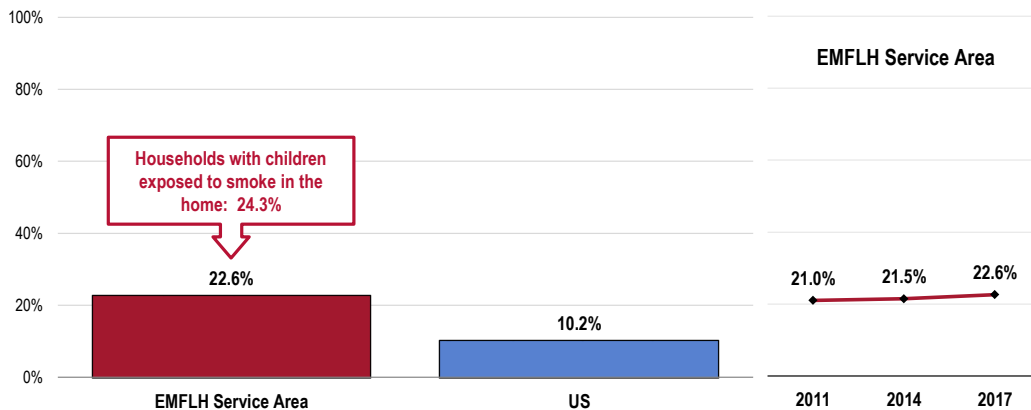
Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 56-57]
 • 2015 PRC National Health Survey, Professional Research Consultants, Inc.
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective TU-4.1]
 Notes: • Asked of respondents who smoke cigarettes every day.

Secondhand Smoke

“In the past 30 days, has anyone, including yourself, smoked cigarettes, cigars or pipes anywhere in your home on an average of four or more days per week?”

The following chart details these responses among the total sample of respondents, as well as among only households with children age 0-17.

Member of Household Smokes at Home

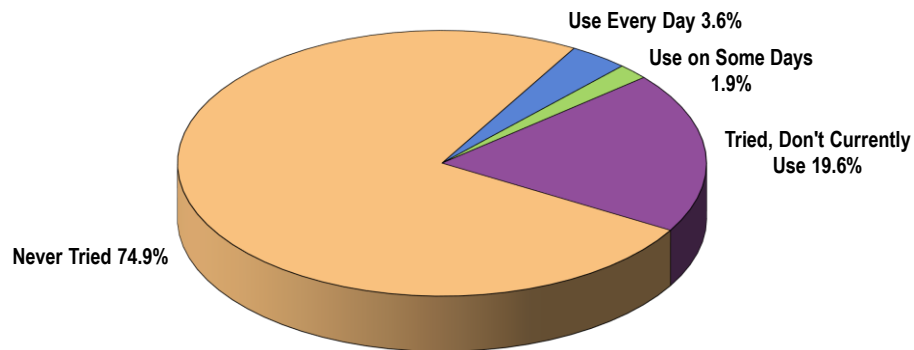


Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 58, 184]
 • 2015 PRC National Health Survey, Professional Research Consultants, Inc.
 Notes: • Asked of all respondents.
 • “Smokes at home” refers to someone smoking cigarettes, cigars, or a pipe in the home an average of four or more times per week in the past month.

E-Cigarette Use

“The next question is about electronic cigarettes, also known as e-cigarettes. These are battery-operated devices that simulate traditional cigarette smoking, but do not involve the burning of tobacco. The cartridge or liquid ‘e-juice’ used in these devices produces vapor and comes in a variety of flavors. Have you ever used an electronic cigarette?”

Electronic Cigarette Use
(EMFLH Service Area, 2017)

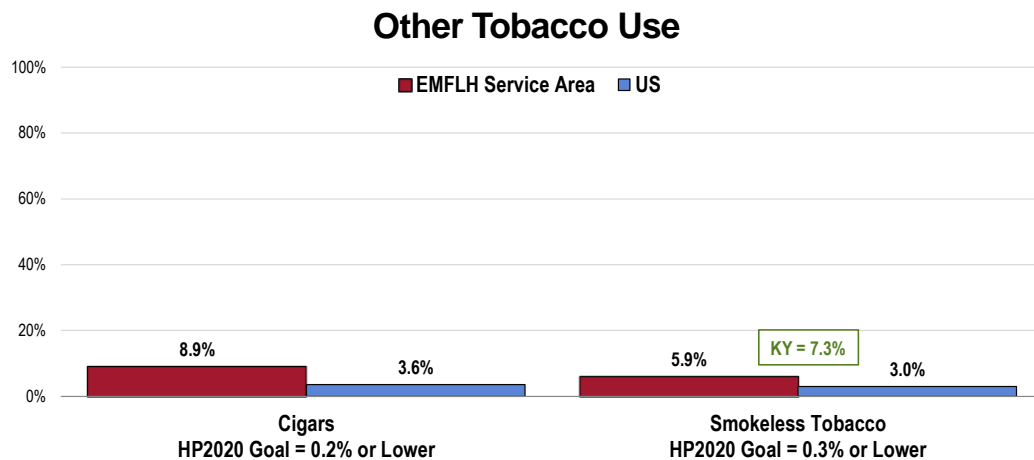


Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 208]
Notes: • Asked of all respondents.

Other Tobacco Use

“Do you now smoke cigars every day, some days, or not at all?”

“Do you currently use chewing tobacco, snuff, or snus every day, some days, or not at all?”

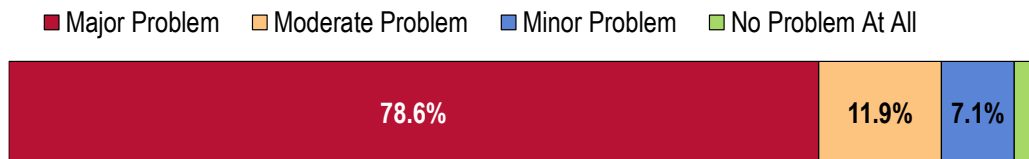


Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 59-60]
• 2015 PRC National Health Survey, Professional Research Consultants, Inc.
• Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2015 KY data.
• US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objectives TU-1.2, TU-1.3]
Notes: • Reflects the total sample of respondents.
• Smokeless tobacco includes chewing tobacco or snuff.

Key Informant Input: Tobacco Use

The following chart outlines key informants' perceptions of the severity of *Tobacco Use* as a problem in the community:

Perceptions of Tobacco Use as a Problem in the Community (Key Informants, 2017)



Sources: • PRC Online Key Informant Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.

Top Concerns

Among those rating this issue as a “major problem,” reasons related to the following:

Prevalence/Incidence

- Although the production of tobacco has decreased in my community, it does not seem that the number of smokers have decreased. I see more and more young adults smoking. – Community Leader*
- Despite all the warnings and lectures, the use of tobacco is still rampant in my community. Being counties that were large producers, changing this will take some time. – Community Leader*
- Most of our clients and a good number of our staff smoke. – Social Services Provider*
- High rate of use and poorly utilized cessation programs. – Physician*
- Tobacco is a socialization norm in Garrard County, just like it is in many other counties. – Community Leader*
- Rural tobacco growing area. – Community Leader*

Comorbidities

- Continued use of tobacco products by all age groups contributes to high level of cancer in Kentucky. – Public Health Representative*
- Cancer and other related diseases continue to increase. – Community Leader*
- Cancer-causing product. – Community Leader*
- Tobacco-related diseases. – Public Health Representative*
- It causes cancer and COPD. – Community Leader*

E-Cigarettes/Vaping

- Smoking is on the decline, but still far too many youth are turning to smokeless and this is not a better option. – Community Leader*
- Use among young people. Vaping. – Social Services Provider*
- Too much tobacco tolerance, especially smokeless tobacco. Smokeless is not harmless. – Community Leader*

Societal Norms

- This is the south, and breaking that habit is difficult. – Community Leader*
- It is accepted. Cultural, kids start at a young age. Tobacco is a major money crop in the area. Problem is it leads to many other major health issues. – Community Leader*

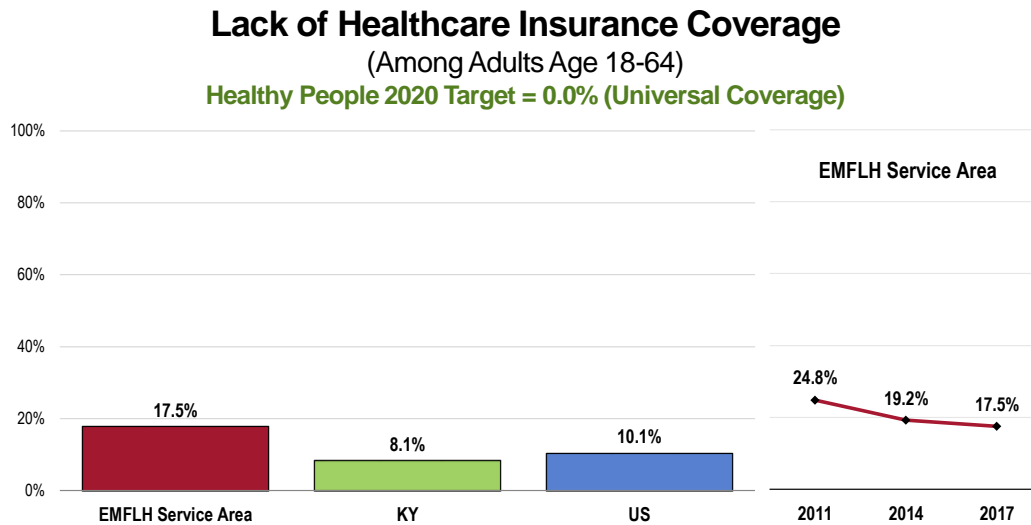
Access to Health Services

Lack of Health Insurance Coverage (Age 18 to 64)

Survey respondents were asked a series of questions to determine their healthcare insurance coverage, if any, from either private or government-sponsored sources. Here, lack of health insurance coverage reflects respondents age 18 to 64 (thus excluding the Medicare population) who have no type of insurance coverage for healthcare services – neither private insurance nor government-sponsored plans (e.g., Medicaid).

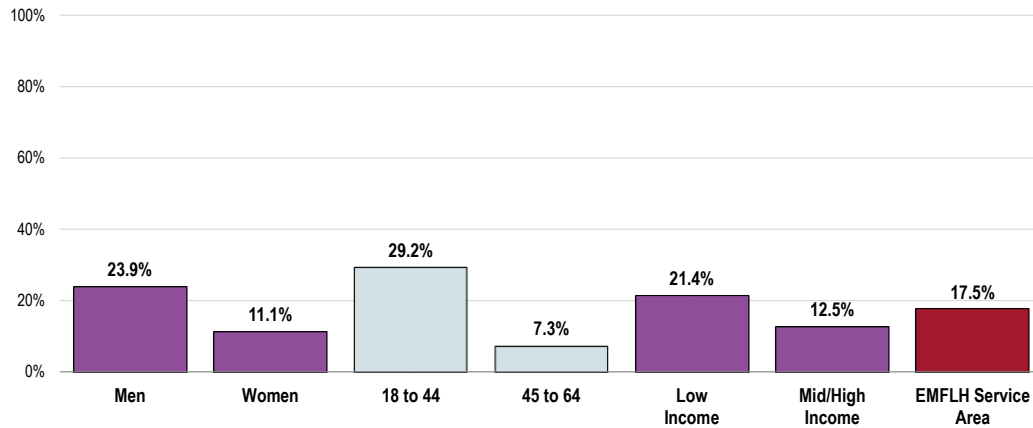
“Do you have any government-assisted healthcare coverage, such as Medicare, Medicaid (or another state-sponsored program), or VA/military benefits?”

“Do you currently have: health insurance you get through your own or someone else's employer or union; health insurance you purchase yourself; or, you do not have health insurance and pay for health care entirely on your own?”



- Sources:
- 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 190]
 - Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2015 KY data.
 - 2015 PRC National Health Survey, Professional Research Consultants, Inc.
 - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective AHS-1]
- Notes:
- Asked of all respondents under the age of 65.

Lack of Healthcare Insurance Coverage (Among Adults Age 18-64; EMFLH Service Area, 2017) Healthy People 2020 Target = 0.0% (Universal Coverage)



Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 190]

• US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective AHS-1]

Notes: • Asked of all respondents under the age of 65.

• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Difficulties Accessing Healthcare

About Access to Healthcare

Access to comprehensive, quality health care services is important for the achievement of health equity and for increasing the quality of a healthy life for everyone. It impacts: overall physical, social, and mental health status; prevention of disease and disability; detection and treatment of health conditions; quality of life; preventable death; and life expectancy.

Access to health services means the timely use of personal health services to achieve the best health outcomes. It requires three distinct steps: 1) Gaining entry into the health care system; 2) Accessing a health care location where needed services are provided; and 3) Finding a health care provider with whom the patient can communicate and trust.

- Healthy People 2020 (www.healthypeople.gov)

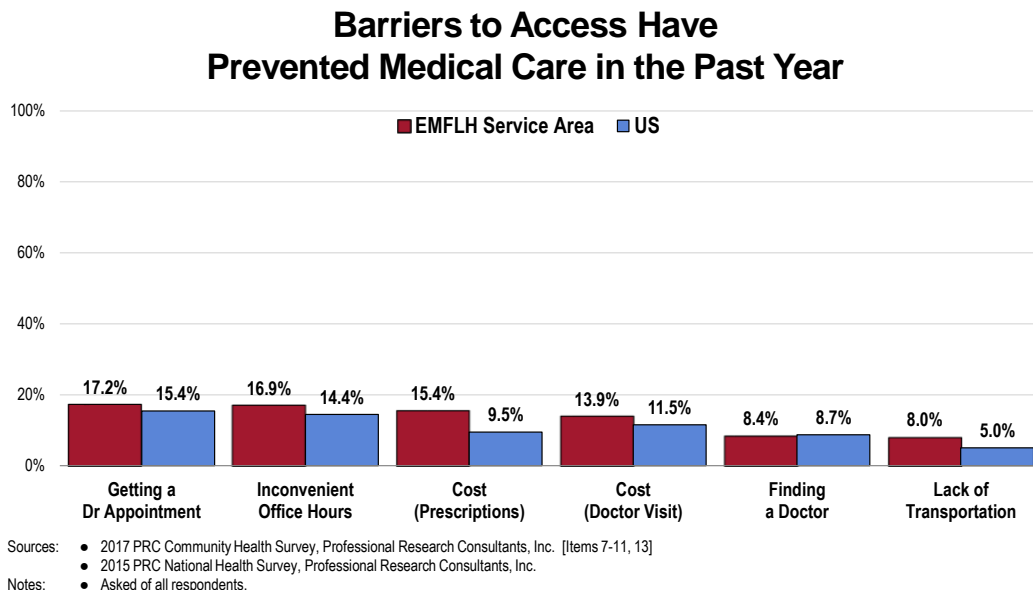
Barriers to Healthcare Access

To better understand healthcare access barriers, survey participants were asked whether any of the following barriers to access prevented them from seeing a physician or obtaining a needed prescription in the past year.

“Was there a time in the past 12 months when...

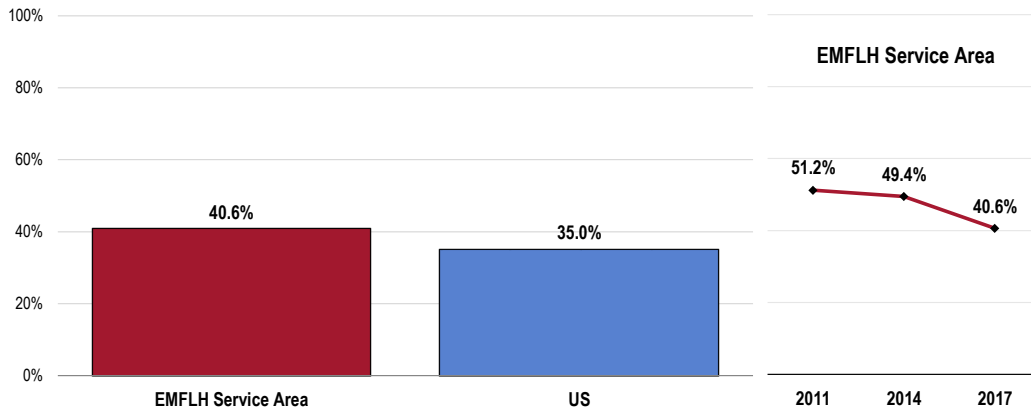
- ... you needed medical care, but had **difficulty finding a doctor?**”
- ... you had difficulty getting an **appointment** to see a doctor?”
- ... you needed to see a doctor, but could not because of the **cost?**”
- ... a **lack of transportation** made it difficult or prevented you from seeing a doctor or making a medical appointment?”
- ... you were not able to see a doctor because the **office hours were not convenient?**”
- ... you needed a **prescription medicine**, but did not get it because you could not afford it?”

The percentages shown in the following chart reflect the total population, regardless of whether medical care was needed or sought.



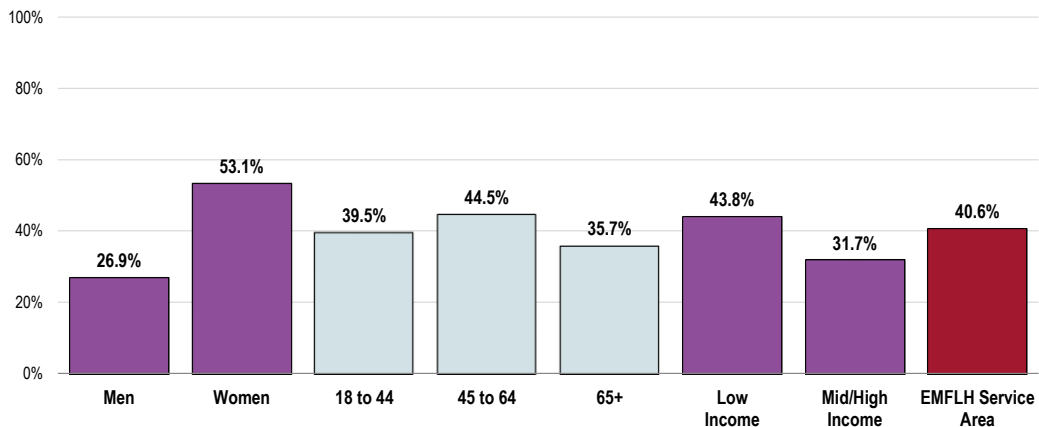
The following charts reflect the composite percentage of the total population experiencing problems accessing healthcare in the past year (indicating one or more of the aforementioned barriers or any other problem not specifically asked), again regardless of whether they needed or sought care.

Experienced Difficulties or Delays of Some Kind in Receiving Needed Healthcare in the Past Year



Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 194]
 • 2015 PRC National Health Survey, Professional Research Consultants, Inc.
 Notes: • Asked of all respondents.
 • Represents the percentage of respondents experiencing one or more barriers to accessing healthcare in the past 12 months.

Experienced Difficulties or Delays of Some Kind in Receiving Needed Healthcare in the Past Year (EMFLH Service Area, 2017)



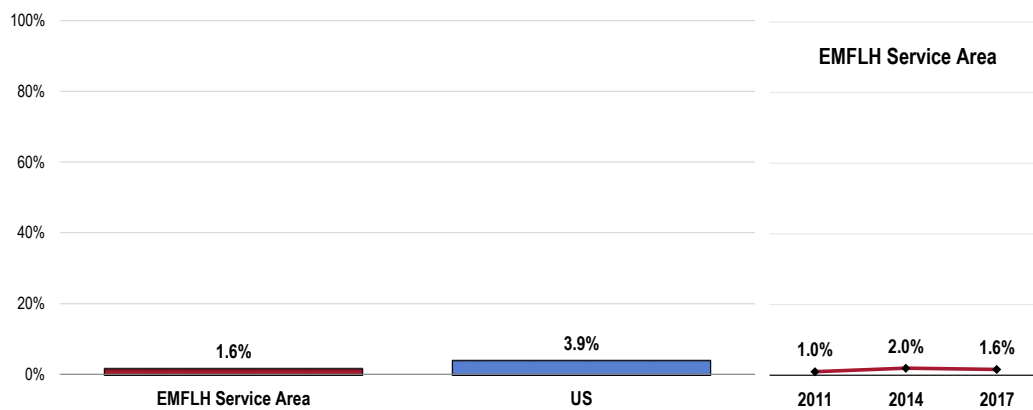
Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 194]
 Notes: • Asked of all respondents.
 • Represents the percentage of respondents experiencing one or more barriers to accessing healthcare in the past 12 months.
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Accessing Healthcare for Children

Surveyed parents were also asked if, within the past year, they experienced any trouble receiving medical care for a randomly-selected child in their household.

“Was there a time in the past 12 months when you needed medical care for this child, but could not get it?” (If yes: “What was the main reason you could not get medical care for this child?”)

Had Trouble Obtaining Medical Care for Child in the Past Year (Among Parents of Children 0-17)

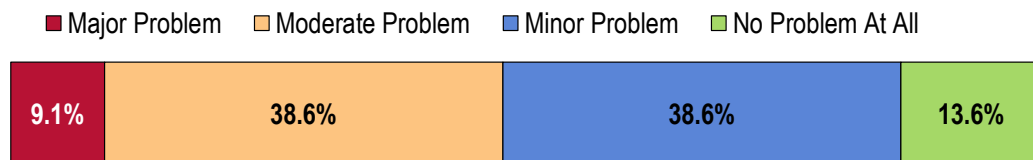


Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 136-137]
 • 2015 PRC National Health Survey, Professional Research Consultants, Inc.
 Notes: • Asked of all respondents with children 0 to 17 in the household.

Key Informant Input: Access to Healthcare Services

The following chart outlines key informants' perceptions of the severity of *Access to Healthcare Services* as a problem in the community:

Perceptions of Access to Healthcare Services as a Problem in the Community (Key Informants, 2017)



Sources: • PRC Online Key Informant Survey, Professional Research Consultants, Inc.
 Notes: • Asked of all respondents.

Top Concerns

Among those rating this issue as a “major problem,” reasons related to the following:

Access to Care/Services

Limited access to primary care. – Physician

Need for more diagnostic facilities. – Community Leader

Primary care. – Physician

Affordable Care/Services

The cost of adequate health care is formidable to many folks. Even those with insurance are reluctant to engage for fear of what the insurance company may refuse to pay. Also, folks do not readily understand what health care they need. – Community Leader

Affordable. – Community Leader

Vulnerable Populations

Assisted living, transition living and residential options for adults with disabilities. – Community Leader

Type of Care Most Difficult to Access

Key informants (who rated this as a “major problem”) most often identified **substance abuse treatment** as the most difficult to access in the community.

Medical Care Most Difficult to Access Locally				
	Most Difficult to Access	Second-Most Difficult to Access	Third-Most Difficult to Access	Total Mentions
Substance Abuse Treatment	100.0%	33.3%	33.3%	5
Mental Health Care	0.0%	33.3%	33.3%	2
Pain Management	0.0%	33.3%	0.0%	1
Elder Care	0.0%	0.0%	33.3%	1

Health Literacy

To measure respondents' ability to understand health-related information, respondents were asked the following questions:

“How often is health information written in a way that is easy for you to understand? Would you say: always, nearly always, sometimes, seldom, or never?”

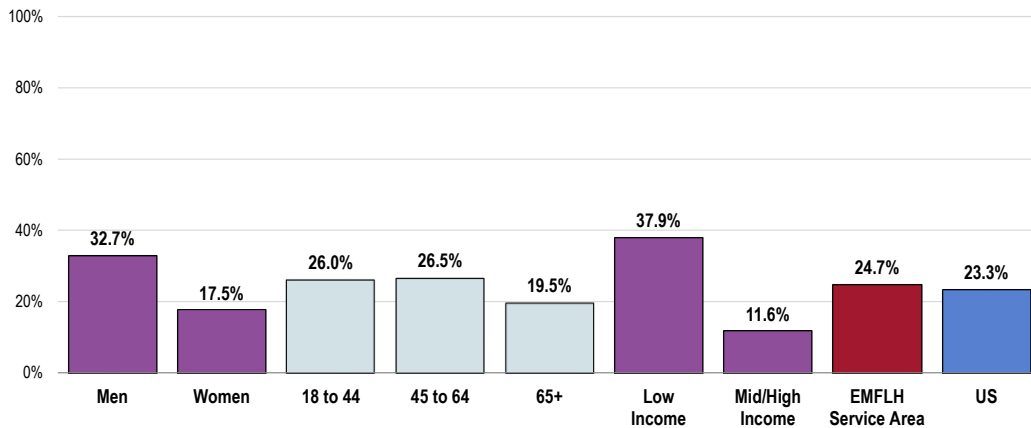
“How often do you need to have someone help you read health information? Would you say: always, nearly always, sometimes, seldom, or never?”

“How often is health information spoken in a way that is easy for you to understand? Would you say: always, nearly always, sometimes, seldom, or never?”

“In general, how confident are you in your ability to fill out health forms yourself? Would you say: extremely confident, somewhat confident, or not at all confident?”

Low health literacy is defined here as those respondents who “seldom/never” find written or spoken health information easy to understand, and/or who “always/nearly always” need help reading health information, and/or who are “not at all confident” in filling out health forms.

Low Health Literacy (EMFLH Service Area, 2017)



Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 195]

- Notes:
- Asked of all respondents.
 - Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.
 - Respondents with low health literacy are those who "seldom/never" find written or spoken health information easy to understand, and/or who "always/nearly always" need help reading health information, and/or who are "not at all confident" in filling out health forms.

Primary Care Services

About Primary Care

Improving health care services depends in part on ensuring that people have a usual and ongoing source of care. People with a usual source of care have better health outcomes and fewer disparities and costs. Having a primary care provider (PCP) as the usual source of care is especially important. PCPs can develop meaningful and sustained relationships with patients and provide integrated services while practicing in the context of family and community. Having a usual PCP is associated with:

- Greater patient trust in the provider
- Good patient-provider communication
- Increased likelihood that patients will receive appropriate care

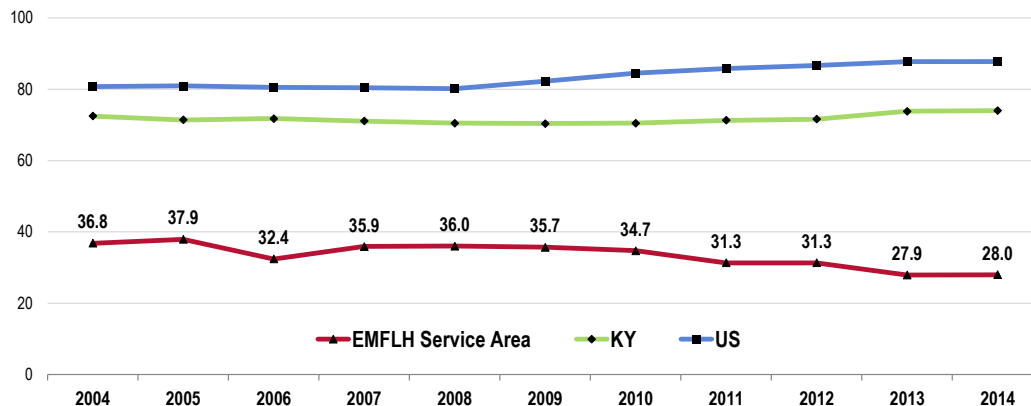
Improving health care services includes increasing access to and use of evidence-based preventive services. Clinical preventive services are services that: **prevent** illness by detecting early warning signs or symptoms before they develop into a disease (primary prevention); or **detect** a disease at an earlier, and often more treatable, stage (secondary prevention).

- Healthy People 2020 (www.healthypeople.gov)

Access to Primary Care

This indicator is relevant because a shortage of health professionals contributes to access and health status issues.

Trends in Access to Primary Care
(Number of Primary Care Physicians per 100,000 Population)



- Sources:
- US Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File.
 - Retrieved March 2017 from Community Commons at <http://www.chna.org>.
- Notes:
- This indicator is relevant because a shortage of health professionals contributes to access and health status issues.
 - These figures represent all primary care physicians practicing patient care, including hospital residents.

Specific Source of Ongoing Care

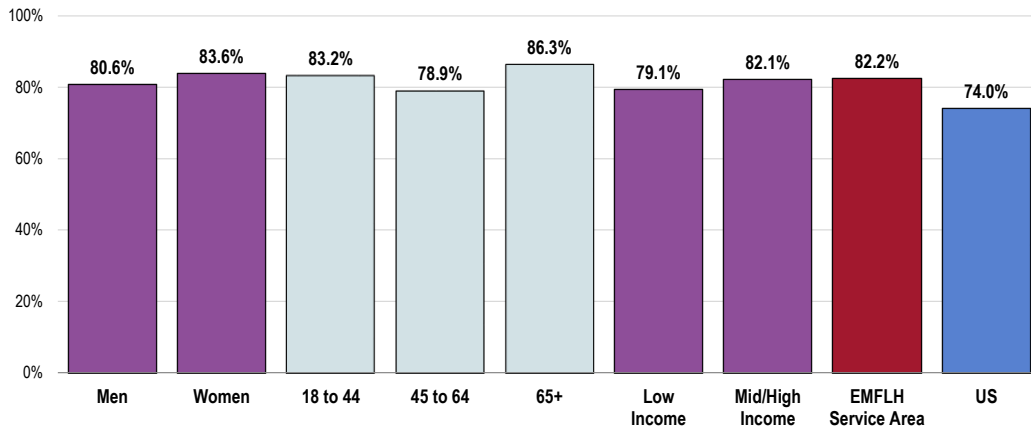
Having a specific source of ongoing care includes having a doctor’s office, clinic, urgent care center, walk-in clinic, health center facility, hospital outpatient clinic, HMO or prepaid group, military/VA clinic, or some other kind of place to go if one is sick or needs advice about his or her health. This resource is crucial to the concept of “patient-centered medical homes” (PCMH).

“Is there a particular place that you usually go to if you are sick or need advice about your health?”

“What kind of place is it: a medical clinic, an urgent care center/walk-in clinic, a doctor's office, a hospital emergency room, military or other VA healthcare, or some other place?”

The following chart illustrates the proportion of EMFLH Service Area population with a specific source of ongoing medical care. Note that a hospital emergency room is not considered a specific source of ongoing care in this instance.

Have a Specific Source of Ongoing Medical Care
(EMFLH Service Area, 2017)
Healthy People 2020 Target = 95.0% or Higher



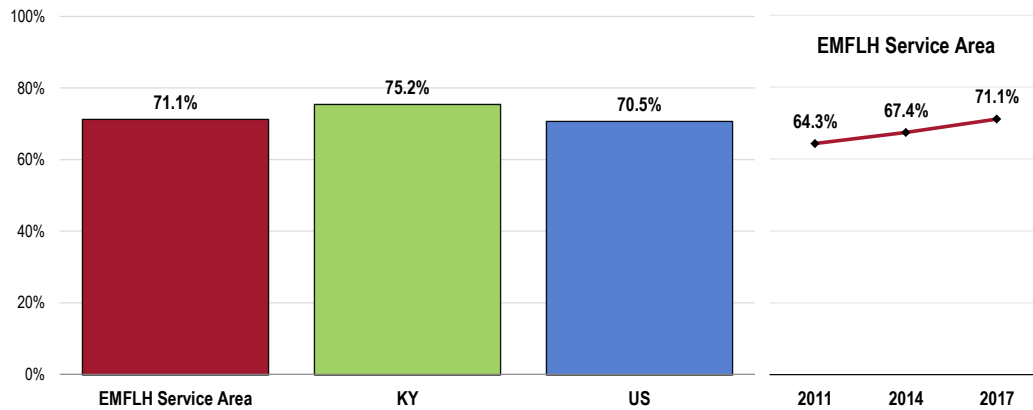
- Sources:
- 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 191-193]
 - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective AHS-5.1]
- Notes:
- Asked of all respondents.
 - Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Utilization of Primary Care Services

Adults: “A routine checkup is a general physical exam, not an exam for a specific injury, illness or condition. About how long has it been since you last visited a doctor for a routine checkup?”

Children: “About how long has it been since this child visited a doctor for a routine checkup or general physical exam, not counting visits for a specific injury, illness, or condition?”

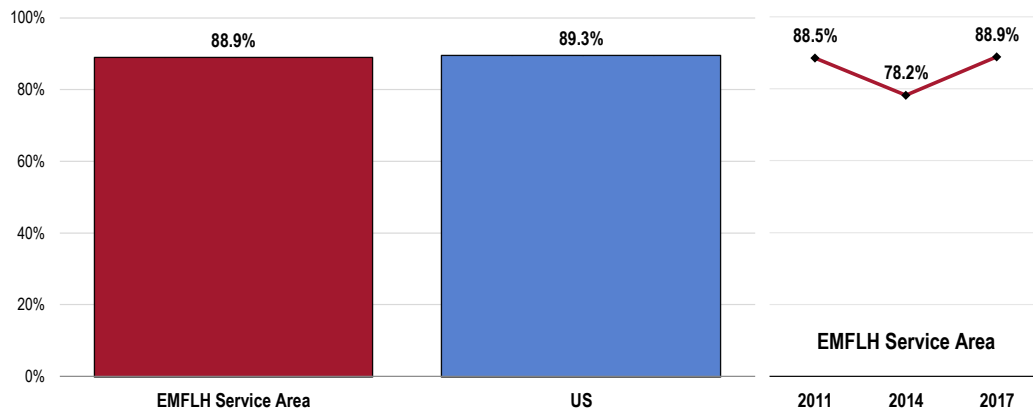
Have Visited a Physician for a Checkup in the Past Year



Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 18]
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2015 KY data.
 • 2015 PRC National Health Survey, Professional Research Consultants, Inc.

Notes: • Asked of all respondents.

Child Has Visited a Physician for a Routine Checkup in the Past Year (Among Parents of Children 0-17)



Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 138]
 • 2015 PRC National Health Survey, Professional Research Consultants, Inc.

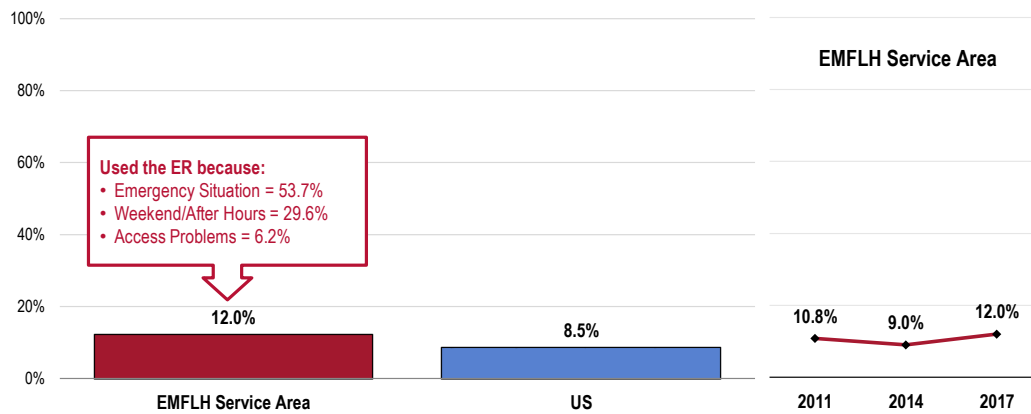
Notes: • Asked of all respondents with children 0 to 17 in the household.

Emergency Room Utilization

“In the past 12 months, how many times have you gone to a hospital emergency room about your own health? This includes ER visits that resulted in a hospital admission.” (Responses below reflect the percentage with two or more visits in the past year.)

“What is the main reason you used the emergency room instead of going to a doctor’s office or clinic?”

Have Used a Hospital Emergency Room More Than Once in the Past Year



Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 22-23]
 • 2015 PRC National Health Survey, Professional Research Consultants, Inc.
 Notes: • Asked of all respondents.

Oral Health

About Oral Health

Oral health is essential to overall health. Good oral health improves a person's ability to speak, smile, smell, taste, touch, chew, swallow, and make facial expressions to show feelings and emotions. However, oral diseases, from cavities to oral cancer, cause pain and disability for many Americans. Good self-care, such as brushing with fluoride toothpaste, daily flossing, and professional treatment, is key to good oral health. Health behaviors that can lead to poor oral health include: **tobacco use; excessive alcohol use; and poor dietary choices.**

The significant improvement in the oral health of Americans over the past 50 years is a public health success story. Most of the gains are a result of effective prevention and treatment efforts. One major success is community water fluoridation, which now benefits about 7 out of 10 Americans who get water through public water systems. However, some Americans do not have access to preventive programs. People who have the least access to preventive services and dental treatment have greater rates of oral diseases. A person's ability to access oral healthcare is associated with factors such as education level, income, race, and ethnicity.

Barriers that can limit a person's use of preventive interventions and treatments include: limited access to and availability of dental services; lack of awareness of the need for care; cost; and fear of dental procedures.

There are also social determinants that affect oral health. In general, people with lower levels of education and income, and people from specific racial/ethnic groups, have higher rates of disease. People with disabilities and other health conditions, like diabetes, are more likely to have poor oral health.

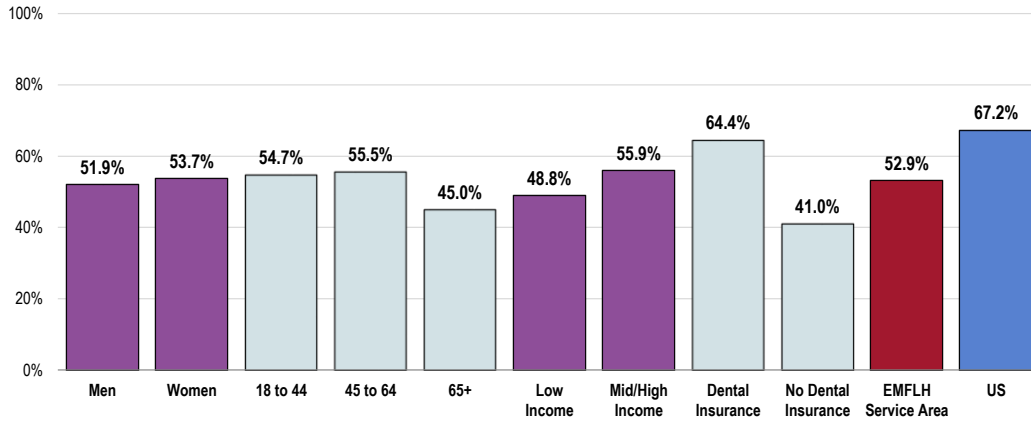
Potential strategies to address these issues include:

- Implementing and evaluating activities that have an impact on health behavior.
 - Promoting interventions to reduce tooth decay, such as dental sealants and fluoride use.
 - Evaluating and improving methods of monitoring oral diseases and conditions.
 - Increasing the capacity of State dental health programs to provide preventive oral health services.
 - Increasing the number of community health centers with an oral health component.
- Healthy People 2020 (www.healthypeople.gov)

Dental Care

“About how long has it been since you last visited a dentist or a dental clinic for any reason?”

Have Visited a Dentist or Dental Clinic Within the Past Year (EMFLH Service Area, 2017) Healthy People 2020 Target = 49.0% or Higher

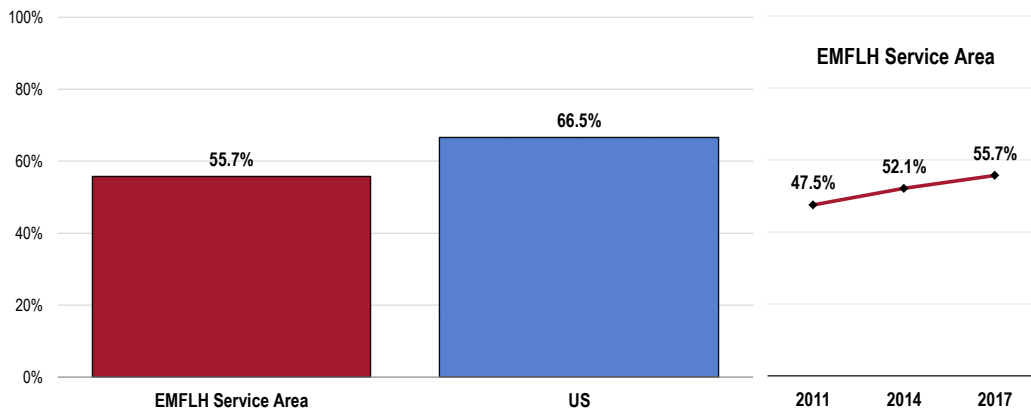


Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 20]
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective OH-7]
 Notes: • Asked of all respondents.
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Dental Insurance

“Do you currently have any health insurance coverage that pays for at least part of your dental care?”

Have Insurance Coverage That Pays All or Part of Dental Care Costs

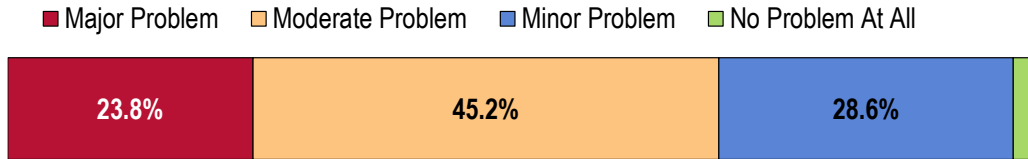


Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 21]
 • 2015 PRC National Health Survey, Professional Research Consultants, Inc.
 Notes: • Asked of all respondents.

Key Informant Input: Oral Health

The following chart outlines key informants' perceptions of the severity of *Oral Health* as a problem in the community:

Perceptions of Oral Health as a Problem in the Community (Key Informants, 2017)



Sources: • PRC Online Key Informant Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.

Top Concerns

Among those rating this issue as a “major problem,” reasons related to the following:

Affordable Care/Services

Oral health is a major problem among adults, due to insurance coverage. – Public Health Representative

Dental work is costly, and in most uninsured residents, it is not a priority. The use of illegal drugs is a major factor to the dental issues in the area. – Community Leader

Prevention/Treatment

Most of our clients lack proper dental hygiene and are missing most of their adult teeth in their middle age. – Social Services Provider

Poor routine dental care and poor routine visits with oral hygiene professionals. – Physician

Prevalence/Incidence

Many people have bad or missing teeth. – Community Leader

Lack of Providers

No local dentist treats children with medical cards. – Public Health Representative

Behavioral Risk

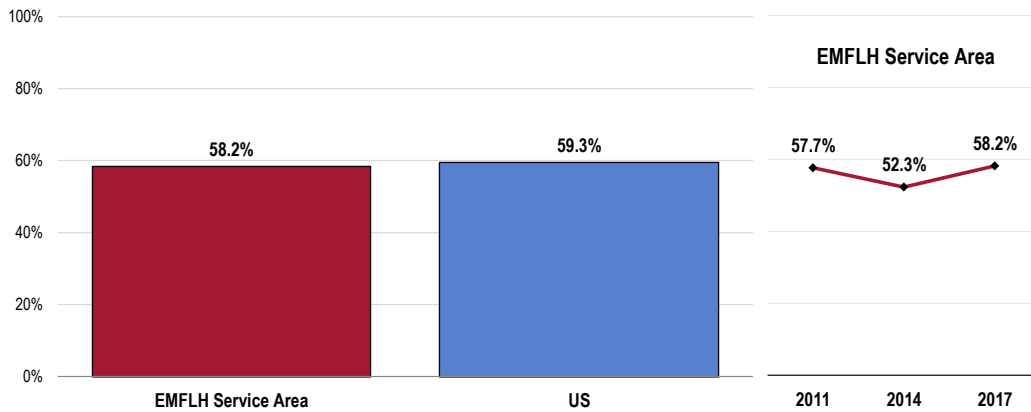
Sugary drinks, tobacco use. – Community Leader

Vision Care

“When was the last time you had an eye exam in which the pupils were dilated? This would have made you temporarily sensitive to bright light.” (Responses in the following chart represent those with an eye exam within the past 2 years.)

See also *Vision & Hearing* in the **Death, Disease & Chronic Conditions** section of this report.

Had an Eye Exam in the Past Two Years During Which the Pupils Were Dilated

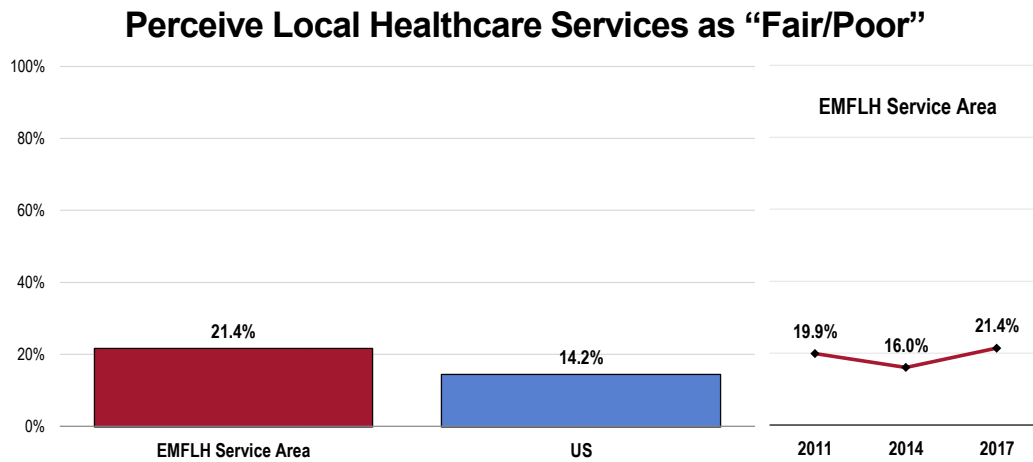


Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 19]
 • 2015 PRC National Health Survey, Professional Research Consultants, Inc.
 Notes: • Asked of all respondents.

Local Resources

Perceptions of Local Healthcare Services

“How would you rate the overall health care services available to you? Would you say: excellent, very good, good, fair or poor?”



Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 6]
 • 2015 PRC National Health Survey, Professional Research Consultants, Inc.
 Notes: • Asked of all respondents.

Resources Available to Address the Significant Health Needs

The following represent potential measures and resources (such as programs, organizations, and facilities in the community) identified by key informants as available to address the significant health needs identified in this report. This list only reflects input from participants in the Online Key Informant Survey and should not be considered to be exhaustive nor an all-inclusive list of available resources. Note, again, that this list reflects the broader region, including not only Casey, Garrard, and Lincoln counties, but also Boyle, Washington, and Mercer counties.

Access to Healthcare Services

- Ephraim McDowell Regional Medical Center*
- Garrard EMT and Ambulance Service*
- Garrard Health Department*
- Lancaster Police Department*
- State Human Resources Department*

Arthritis, Osteoporosis & Chronic Back Conditions

- Doctor's Offices*
- Elderly Transportation System*
- Health First Chiropractic*
- Lincoln County Health Department*
- McDowell Wellness Center*
- Ortho Spine Center*
- Pharmacy*

Cancer

- American Cancer Program*
- Breast and Women's Health Center*
- Cancer Center*
- Commonwealth Cancer*
- Danville Cancer Center*
- Danville/Boyle County Health Department*
- Diagnostic Equipment*
- Doctor's Offices*
- Ephraim McDowell Cancer Center*
- Ephraim McDowell Regional Medical Center*
- Garrard Extension Office*
- Get Going Garrard Program*
- Health Department*
- Health Fairs*
- Hospice*
- Hospice of the Bluegrass*
- Kentucky Colon Screening Program*
- Kentucky Cancer Program*
- Kentucky Women's Cancer Screening Program*

- Lincoln County Breast and Cervical Cancer Coalition*

- Preventative Screenings*
- Relay for Life*
- School System*
- The Presbyterian Church*

Chronic Kidney Disease

- Dialysis Center*
- Doctor's Offices*
- Ephraim McDowell Regional Medical Center*

Dementias, Including Alzheimer's Disease

- Adult Day Care*
- Alzheimer's Research*
- Doctor's Offices*
- Ephraim McDowell Health*
- Ephraim McDowell Regional Medical Center*
- Mental Health Services*
- Morning Pointe*
- Nursing Home*
- Senior Citizens Center*

Diabetes

- Adult Day Care*
- Bluegrass Clinic Diabetes Education Program*
- Children and Family Resources*
- Dialysis Center*
- Doctor's Offices*
- Ephraim McDowell Regional Medical Center*
- Fitness Centers/Gyms*
- Health Department*
- Health Fairs*
- Hope Clinic*
- James B. Haggin Memorial Hospital*
- Lancaster Life Center*
- Lincoln County Health Department*

McDowell Wellness Center
 Mercer County Health Department
 Parks and Recreation
 School System
 University of Kentucky Extension Office
 Weight Clinic
 Wellness Centers

Family Planning

Church
 Danville/Boyle County Health Department
 Family Members
 Garrard Health Department
 Health Department
 School System

Hearing & Vision

Adult Day Care
 Lincoln County Judge Executive Office
 Lincoln County Lion's Club
 School System

Heart Disease & Stroke

Cardiovascular Institute
 Doctor's Offices
 Ephraim McDowell Regional Medical Center
 Fitness Centers/Gyms
 Health Department
 Health Fairs
 Hospital
 Lancaster Life Center
 Lincoln County Extension Office
 Lincoln County Health Department
 School System
 Stanford/Lincoln County Get Healthy Committee
 Wellness Centers

HIV/AIDS

Ephraim McDowell Regional Medical Center
 Health Department

Immunization & Infectious Diseases

Health Department
 Doctor's Offices
 Ephraim McDowell Fort Logan Hospital
 Ephraim McDowell Health
 Lincoln County Health Department

Lincoln County School District

Infant & Child Health

Ephraim McDowell Regional Medical Center
 Health Department
 Social Services Agencies

Injury & Violence

Bluegrass.org
 Health Department
 Hospital
 Kentucky Agency for Substance Abuse Policy

Mental Health

Bluegrass.org
 Bluegrass/Lincoln County
 Communicare
 EMT Response Units
 Ephraim Adult Inpatient Short Term Unit
 Ephraim McDowell Health
 Ephraim McDowell Regional Medical Center
 Mental Health Services
 Police Department
 School System

Nutrition, Physical Activity & Weight

24 Hour Fitness
 Adult Day Care
 Anderson-Dean Park
 Bunny Davis Center
 Community Action
 Doctor's Offices
 Ephraim McDowell Regional Medical Center
 Fitness Centers/Gyms
 Fitness Edge
 Grocery Stores
 Health Department
 Hospital
 Lincoln County Extension Office
 Lincoln County Health Department
 Locally Grown Produce
 McDowell Fitness Center
 McDowell Wellness Center
 Parks and Recreation
 Planet Fitness
 School System

Shaker Village
 Stanford/Lincoln County Get Healthy
 Committee
 University of Kentucky Extension Office
 Weight Watchers
 Wellness Centers
 YMCA
 Zumba

Oral Health

Dentist's Offices
 Doctor's Offices
 Health Department
 Jessamine County Health Department
 Lincoln County Oral Health Coalition
 Mercer County Health Department
 University of Kentucky Dental Bus

Respiratory Diseases

Bunny Davis Center
 Doctor's Offices
 Health Department
 Millennium Park
 Planet Fitness
 Respiratory Therapy
 School System
 Smoking Cessation Program
 Wellness Centers

Sexually Transmitted Diseases

Department for Public Health
 Doctor's Offices
 Ephraim McDowell Fort Logan Hospital
 Lincoln County Health Department
 Urgent Care Center

Substance Abuse

Alcoholics Anonymous/Narcotics
 Anonymous
 AAA
 Adoption Support for Kentucky
 Agency for Substance Abuse Policy
 Bluegrass.org
 Bluegrass/Lincoln County Health
 Department
 Boyle County Detention Center Intensive
 Outpatient Program
 Casey County Drug Court
 Casey County Health Department
 Casey County Hospital

Circle of Hope
 Doctor's Offices
 Ephraim McDowell Health
 Ephraim McDowell Regional Medical
 Center
 Health Department
 Hope Network
 Hope Over Heroin
 Isaiah House
 Liberty Ranch Rehab Center
 Lincoln County Health Department
 Mental Health Services
 Mercer County Health Department
 Police Department
 Recovery Roadhouse
 School System
 SelfRefind
 Shepherd's House
 The Shepherd House

Tobacco Use

Boyle County Health Department
 Counseling
 Doctor's Offices
 Ephraim McDowell Health
 Ephraim McDowell Regional Medical
 Center
 Health Department
 Lincoln County Health Department
 Lincoln County Teens Against Tobacco
 Use
 Pharmacy
 Private Employers
 Quit Smoking Hypnosis
 School System
 Smoking Cessation Program

Appendix



Professional Research Consultants, Inc.

Evaluation of Past Activities

As a result of the 2014 CHNA, several priority health issues were identified by EMH community services in collaboration with key stakeholders. Collaboration with community health departments, extension offices, and churches have allowed for a goal to be met regarding screening for modifiable lifestyle factors related to cardiovascular disease as well as education and referral as needed. There were a total of 16,120 screening tests completed in 2015-2016. These tests include but are not limited to total cholesterol/HDL ratio, blood sugar, stroke risk screening utilizing the American Stroke Risk Association Risk Score Card, heart risk screening utilizing the Heart Risk Score Card, blood pressure, and BMI. Of the 16,120 tests, 47% were out of range and those participants were referred for abnormal or at risk results. Lifestyle education and education regarding early heart attack care (EHAC), and signs and symptoms of a heart attack was provided or distributed by a Registered Nurse. Trends from the current CHNA show no significant change in trend line from 2014 survey to current related to percent of heart disease. As a result of a Healthy People: Health Communities Research Study, individuals' lab results were screened every six months for three years to determine individual stroke risk. Registered Nurse consultation was incorporated immediately after, to establish goals and lifestyle changes. As a result of the study, an improvement in high density lipoprotein was observed. Decreasing trend lines in total cholesterol, low density lipoprotein, triglycerides, and the red score on the stroke risk scorecard was documented.

Cancer was another priority chosen post review of the 2014 CHNA. The impact of actions taken since last reporting period shows no significant change in colorectal screening; however, the overall age adjusted death rate of cancer showed an improvement in trend line for the service area. As part of the annual screening process, 386 colorectal screening kits were distributed and all results were provided back to the participant and their primary care provider. Screening for skin damage was conducted at several locations and education regarding sunscreen usage to school age groups as well as adults was provided. In collaboration with the county Parks and Recreation department, 4H camps, athletic events, stock yards, lumber yards, and extension offices, 374 individuals were screened for sun damage and or skin cancer risk. A local primary care provider and the Commonwealth Cancer Center acted as partners for providing diagnosis, treatment, referral, and support groups. The trend line from the 2014 CHNA to current showed no significant change in rate of skin cancer.

Access to health services was a priority issue identified. EMH goal was to improve health care access for primary care and specialty care in the region by augmenting the services already available. Recruitment efforts in 2015-2016 revealed EMH assisted five private practices to secure providers to the community. Those provider specialties included OB/GYN, General Surgery, Orthopedics, Podiatry, and Family Practice. In addition to the private practices, thirteen providers were secured to the service area and included Neurology, Internal Medicine, Pulmonology, Family Practice, Intensivist, Cardiology and Urology.